Kent's Health Inequalities Action Plan

MIND THE GAP Building bridges to better health for all

2012/15

Kent County Council

Foreword

Graham Gibbens
Cabinet Member for Adult Social Care and Public Health

We live in an age where everyone's health is improving and we are all living longer. Only 100 years ago, the average lifespan was 47 years – and now it is 80 years.

However, just like 40 years ago, if you are wealthier you are likely to live longer and have better health.

What happens to you during your lifetime has a huge impact on your health. Poor health is linked to whether you drink or smoke, what you eat, your qualifications, the job you do, how much you earn and where you live.

With so many factors having an affect on our health, central government has put responsibility for public health back in the hands of local authorities. The reasoning is that councils have local influence over many of those things that affect our health, from housing, regeneration and planning to education, leisure and road safety. Of course, services for children, young people and vulnerable adults also play a vital part.

Taking on these responsibilities is something I am pleased to do because tackling disadvantage – and unfairness – in our communities is one of our three ambitions. Indeed, it is part of our Community Strategy – the Vision for Kent.

We want all residents in Kent to live longer, healthier lives, regardless of where they live or how much money they have. We want the lives of the poorest to improve fastest so that the inequality that exists between the richest and poorest in our communities is reduced. This is especially important at a time when more people are finding it harder to make ends meet.

This plan sets out what we are going to do to fulfill our new responsibilities to tackle health inequalities in our communities and to help keep us all – especially those with fewer advantages – to feel well and stay healthy.

I welcome and recommend this action plan to you and look forward to seeing the difference we can make to the lives of the people of Kent.

Meradin Peachey
Director for Public Health

This Action plan sets out how partners- Health, Districts, the 3rd Sector and others across Kent -will fulfill our responsibilities and it refreshes the commitment and strengthens the contributions made by all key stakeholders. It has a wider and more collective ownership and commitment to health inequalities, so that we can all work together to really make a difference. This will require a focused, targeted approach to inequalities and strong partnerships with the Kent Community to gain insight into attitudes and behaviours that prevent lifestyle change.

The priorities and actions come from National Programmes and our Joint Strategic Needs Assessment and guidance such as the Healthy Child Programme, Health and Social Care Bill and the Public Health Outcomes Framework are referenced throughout.
Our aspirations to achieve a measure of good practice are described under the 'What Good Will Look Like in 2015' section. This is where the scaling up and systematic delivery of effective programmes with robust outcomes will come into effect and where challenges, risks and innovation will need to be applied.

This Action Plan, driven by the Joint Strategic Needs Assessment and Marmot's Life-course objectives provides a clear, focused commitment to how and by when we will see outcomes to reduce to the inequalities gap.

Kent County Council is committed to delivering services that will support this action plan but success will depend on all our partners' ongoing commitment and support. Together we can make a difference.

Contents

What people in Kent think

"It's great we now have something that says how things should be happening"

"we can use this to ask our council and local services why they are not doing what it says"

"It's about personal choice, and how the agencies that are around 'pitch' their services at you..... they don't offer us the right stuff at the right time, and then wonder why things go wrong"

"They (council services) shouldn't decide how locally they can do this, people like us should be spoken with so we can tell them… we want to be involved"

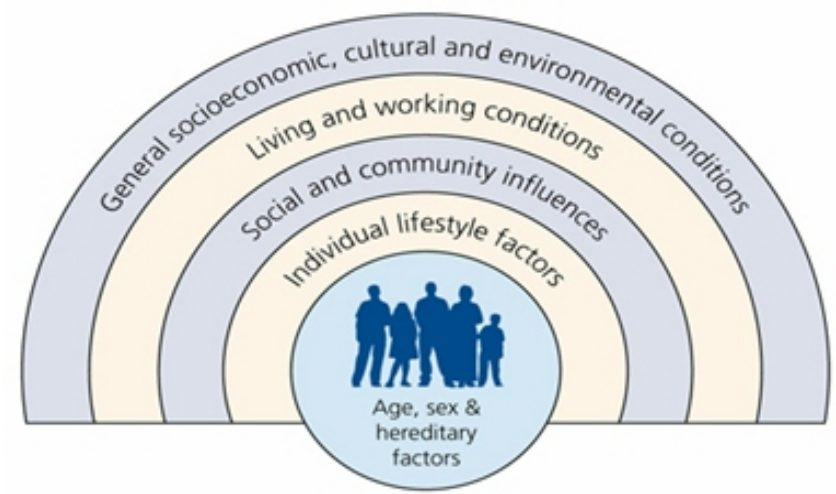
"It's a tool to make sure we don't just get the scraps, but have a fair shot too"

Introduction

1. Health Inequalities in Kent

Health inequalities are the result of a set of complex interactions, including:

- the long-term effects of a disadvantaged social position
- differences in access to information, services and resources
- differences in exposure to risk
- lack of control over one's own life circumstances
- a health system that may reinforce social and economic inequalities.



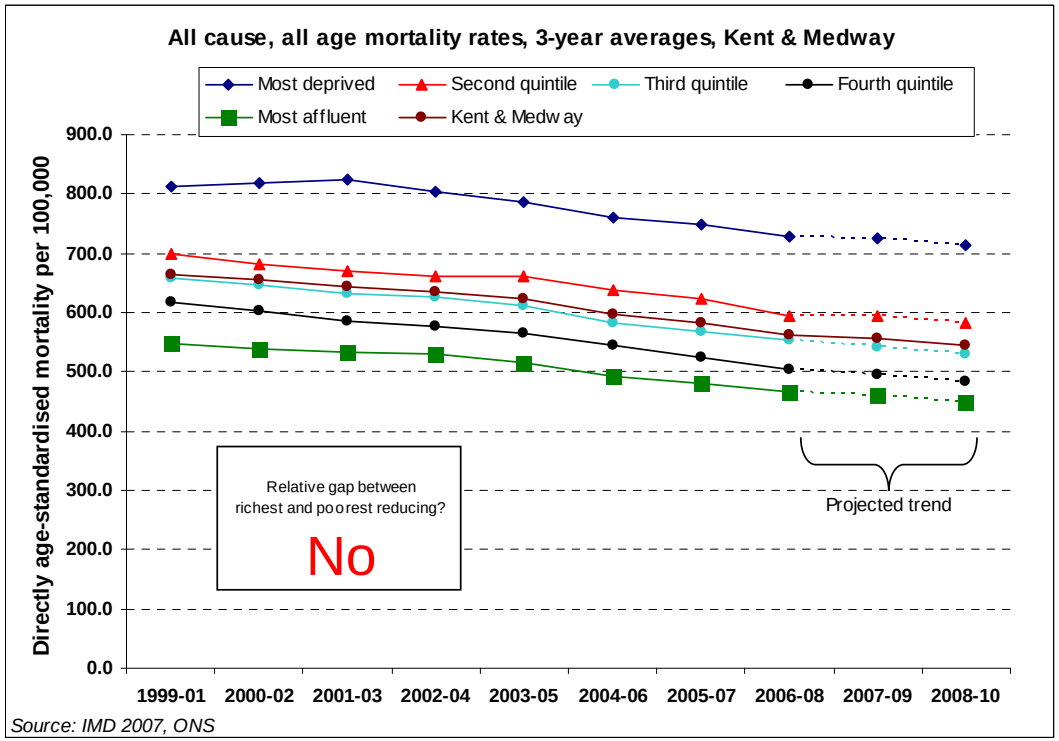
Dahlgren and Whitehead (1991)

These factors all affect a person's ability to withstand the stressors – biological, social, psychological and economic – that can trigger ill health. They also affect the capacity to change behaviour.

Measures of health inequality are not primarily about health but of socio-economic status which has an impact on health and can lead to disease. Relative deprivation impacts on a person's ability to participate in or have access to employment, occupation, education, recreation, family and social activities and relationships which are commonly experienced by the mainstream. People in deprived circumstances often do not present with major health problems until too late. Barriers to presentation include structural issues such as poor access and transport; language and literacy problems; poor knowledge; low expectation of health and health services; fear and denial and low self esteem.

All age all cause mortality is the accepted convention for measuring overall health status of communities. By showing mortality rates charted to deprivation we can demonstrate that the overall mortality gap between the richest and poorest in Kent is increasing over time and that there is a highly significant correlation between relative deprivation and life expectancy across the county as a whole and for many of the district council areas. Poverty exists all over Kent and is not confined to specific areas. Although Kent has a better than England average inequality in male life expectancy (8.2years) it is still worse than the South East region average of 7.3years and there is still a lot more to be done to tackle the life expectancy of the most to the least deprived *(Health Inequalities in Kent – Two Years on from Fair Society Healthy Lives (The Marmot Review – February 2012))*

All age, all cause mortality rates, 3-year averages, Kent & Medway



For more information at **a District level** *Trends in Health Inequalities in Kent and Medway 2010* (Dr J. Sexton) is available at www.kmpho.nhs.uk/health-inequalities/life-expectancy/?assetdet957414=96348

Slope Index of Inequality for Life Expectancy 2005-2009

	Males	Females
	Slope Index of Inequality (years)	**Slope Index of Inequality (years)**
Slope Index score represents the gap in years of life expectancy at birth between the most deprived and least deprived in the local authority area.		
Kent CC	8.1	5.0
Ashford	4.3	2.2
Canterbury	6.8	4.7
Dartford	8.1	5.7
Dover	8.0	2.3
Gravesham	9.1	4.2
Maidstone	7.2	5.9
Sevenoaks	4.3	1.6
Shepway	8.4	7.1
Swale	7.7	4.9
Thanet	12.3	7.2
Tonbridge and Malling	7.2	5.4
Tunbridge Wells	4.9	0.6

Source: APHO 2012: see also Objective 4

2. What this Plan will do to tackle Health Inequalities in Kent

We will transform health inequalities in Kent by reducing the gap in health status between our richest and poorest communities.

Most importantly we will improve health and wellbeing for everyone in Kent but we will “Improve the health of the poorest fastest” so that more people will live longer in better health and the difference in life expectancy within and between communities in Kent will reduce.

What we will achieve by 2015:

- Increase breast-feeding initiation rates and prevalence at 6-8 weeks in all parts of Kent
- Roll out Total Child Pilot to schools to help schools identify health and wellbeing issues for pupils
- Increase proportion of Young People (16-18) & (18-24) in full time education or employment
- Reduction in the levels of inequalities for Life Expectancy for Males and Females
- Reduce homelessness and its negative impact for those living in temporary accommodation
- Reduce the rate of deaths attributable to smoking in all persons

The Economic Benefit of Reducing Inequalities will yield tangible results for individuals, families and communities. For example, each teenage pregnancy avoided will save a total of £400,000 in extra costs to the taxpayer in health, benefits, tax from earnings and lost productivity. 9417 more people in Kent will be helped to stop smoking this year (2011/12) and on average every smoker who quits will save over £2000 pa. Every pound invested in tobacco control and smoking cessation will save £11 in health, social care and related costs.

3. Who will Do What

The Action Plan provides a framework and tools to identify, analyse and evaluate actions that can contribute to reducing health inequalities.

'People's health and well-being will be at the heart of everything local councils do. It's nonsense to think that health can be tackled on its own. Directors of public health will be able to champion local co-operation so that health issues are considered alongside housing, transport, and education.'

Andrew Lansley, Secretary of State for Health, November 2010

Local Authority

Kent County Council is taking on new responsibilities for Public Health and for tackling the social determinants of health inequalities. However we will only succeed if all local authorities and our partners across Kent are engaged and committed to reducing health inequalities in their areas.
The objectives and priorities are set by the Marmot review and the Kent Joint Strategic Needs Assessment but the actions can be changed to suit different organisations, districts and localities, functions or issues. We are hoping that district councils and their partners will use the framework of the plan to identify their own local actions that will impact on inequalities throughout the life course. Different functions such as Housing, Mental Health and Tobacco Control can do the same.
Some districts in Kent are proposing Locality arrangements. As these arrangements evolve alongside new Clinical Commissioning groups this action plan will play an important role in informing planning, commissioning priorities and decisions.

Partnership Working
Kent has embraced this challenge through the Sustainable Community Strategy *Vision for Kent 2012-2022*. The Vision for Kent sets out three Countywide Ambitions that will guide the direction of public services in Kent for the next ten years:

- Ambition 1 - To grow the economy
- Ambition 2 - To tackle disadvantage
- Ambition 3 - To put citizens in control

It puts emphasis on economic regeneration, work creation, supporting vulnerable people, a good standard of living and the development of healthy and sustainable places and communities. This Action Plan is sponsored by Ambition Board 2 and is integral to work in Kent to tackle disadvantage.

Primary Care and Clinical Commissioning Groups (CCGs)
The NHS Commissioning Board and CCGs will need to adopt a process that demonstrates what they have done to fulfill their health inequalities duties on an annual basis including ensuring that access to NHS care is demonstrably fair and equitable across different groups, e.g. age, sex, social class, geography. The Four Point Approach (see page 8) developed to deliver this Action Plan is recommended as a robust screening and assessment tool that can detail a plausible audit trail to addressing inequalities. Emphasis on reducing inequalities should be focused on delivering screening and prevention programmes including Health Checks, immunisations, early diagnosis and reducing the burden of Long Term Conditions to the right populations not just those that present themselves.

Acute Services
The NHS Outcome Framework defines and supports clinical outcomes, including the reduction of health inequalities for NHS commissioners, encouraging them to work in partnership with the public health system to improve health and wellbeing and reduce health inequalities, underpinned by NICE quality standards or other accredited evidence. In particular, the outcomes frameworks should be aligned, with further shared outcomes across the NHS and public health system (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132085.pdf)
This should also be demonstrated through “make every contact count” a key component of the NHS Future Forum’s SIX POINT PLAN to use every contact with an individual to maintain or improve their mental and physical health and wellbeing where possible. This will be included in the NHS Constitution.

4. The Tools we Use

What do we need to do: The Action we need to take is summarised in this Four Point Approach.

Deliver this 4 POINT APPROACH:

i) **Target the population appropriately** by using local intelligence, data from the JSNA, health profiles

ii) **Apply the HINST Christmas Tree Tool** to commissioning to ensure interventions are delivered effectively to achieve population outcomes.

iii) **Assess impact** on health inequalities by applying the wellbeing screening tool and by listening to local communities

iv) **Ownership** and delivery of priorities through locally agreed action plans

I. **Targeting the population** - Understanding the needs of our communities.

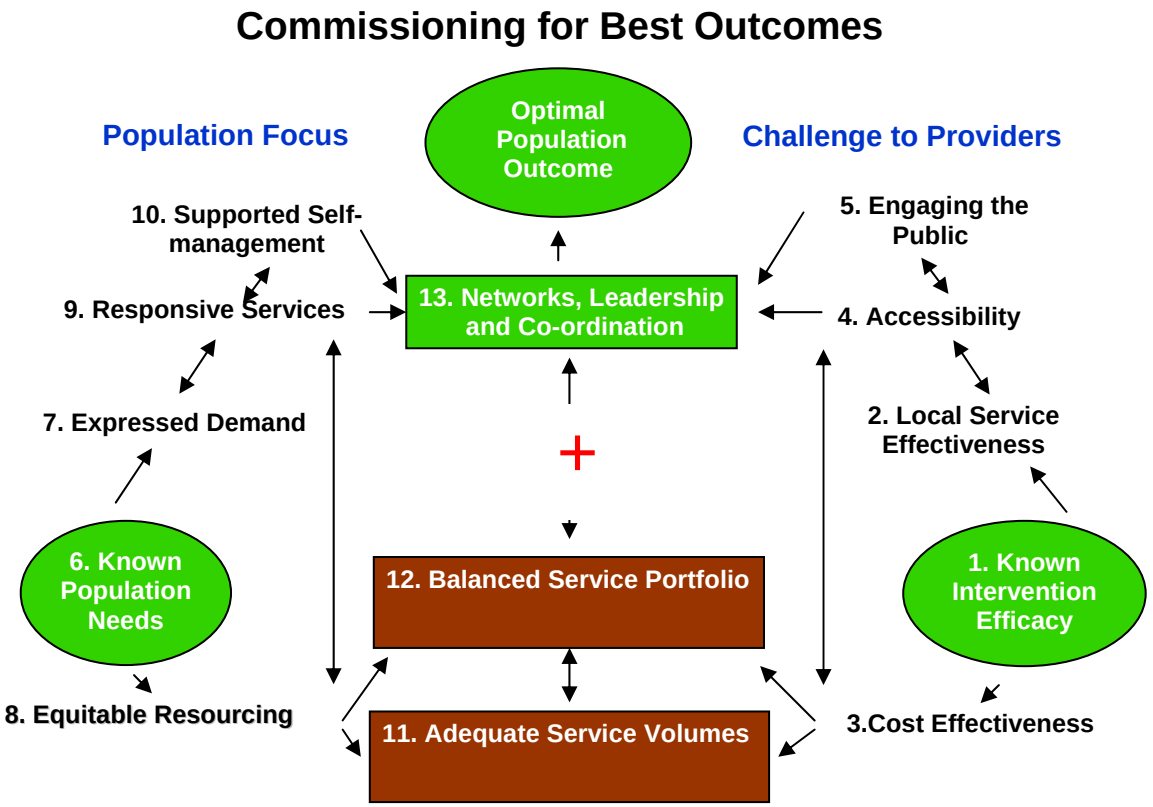
The focus of response strategies, both county and locality based, should be targeted in accordance with the principles of equity (greater attention and investment to areas and issues of greatest need) in order to maximise and improve overall outcomes.

There is a wealth of research, information, data and sophisticated profiling tools available in Kent to help identify those areas and issues of greatest need.

- Joint Strategic Needs Assessment and Social Care maps (www.kmpho.nhs.uk/jsna/)
- District and Kent Health Profiles from the Department of Health (www.apho.org.uk/resource/view.aspx?QN=HP_RESULTS&GEOGRAPHY=29)
- Key facts about the County of Kent including Deprivation, population, employment, housing can be found at KCC Research and Intelligence Unit website (www.kent.gov.uk/your_council/kent_facts_and_figures.aspx)

ll. **Strategic Commissioning –** using the HINST Christmas Tree Model (right)
The HINST Team developed the Christmas Tree to help model the potential contribution of interventions necessary to achieve targets. It has the potential to support commissioners to engage in the systematic delivery of the best health outcomes from a given set of interventions and ensure that local people have a voice

lll. **Impact Assessment -** Supporting Operational effectiveness through the development of a health inequalities wellbeing screening tool will provide a model for assessing and measuring the of impact of interventions which are integral to cost effective commissioning and delivering targets and positive outcomes for the population. This approach will also provide the Health and Wellbeing Board with evidence of improvements to facilitate access to the health premiums that the Government is proposing to use to reward progress on specific public health outcomes.



The screening tool developed by the National MWIA Collaborative (England) and published in May 2011 will put wellbeing at the centre of our planning as a key part of addressing inequalities.

Commissioners should be aware of a range of tools available to help them assess cost benefits. The National Institute for Health and Clinical Excellence (NICE) proposed a three step approach to determine the benefits of public health interventions (2010) and recommended the need for benefits to be reported in 'natural units', such as life years saved and reductions in hospital admissions as well as through financial modeling.

1: **Give every child the best start in life**

Improving health in the early years of life contributes considerably to better health outcomes in later life, with reduced levels of diabetes, coronary heart disease and hypertension, all of which have a significant impact on the NHS as well as wider society, children and their families.

Life-Course 1: Key Priority for Making a Difference in Kent
Increase breast-feeding initiation rates and prevalence at 6-8 weeks in all parts of Kent

The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. (Marmot Review 2010)

Objective 1A: Give every child the best start in life (Conception-9 months)

Delivered through Maternity Matters; Infant Feeding Action Plan

Priorities

1A: Support good health and wellbeing in pregnancy and the newborn

1a.1 Help increase the number of healthy births

1a.2 Increase breast-feeding initiation rates and prevalence at 6-8 weeks in all parts of Kent - **Priority Issue for Kent**

Actions

1a.1.1 Strengthen midwifery and stop smoking resources to reduce smoking in pregnancy

1a.1.2 Strengthen buddy role through Midwifery

1a.1.3 Campaign to promote good health in pregnancy

1a.1.4 Ensure teenage mothers have additional support

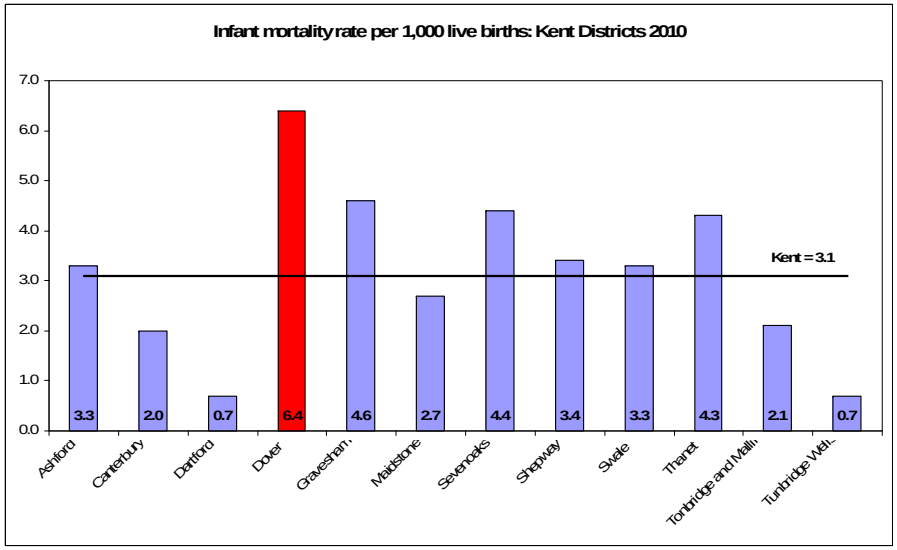
1a.1.5 Supporting pregnant women who are experiencing domestic violence

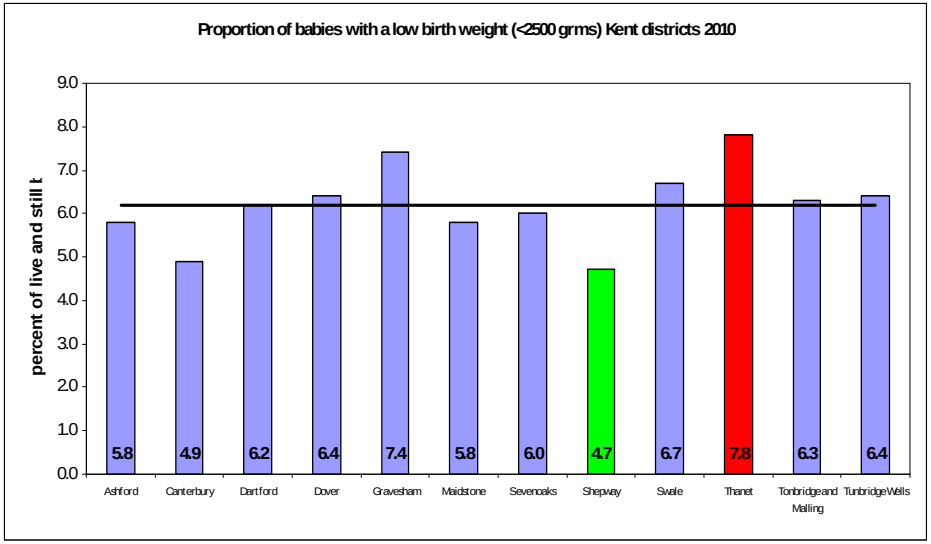
1a.2.1 Support infant feeding by achieving UNICEF's Baby Friendly accreditation and by putting the infant feeding action plan in place

1a.2.2 Develop a needs assessment for breastfeeding to support targeting and commissioning of services

Objective 1A. Give every child the best start in life

Priority 1a.1 Help increase number of healthy births





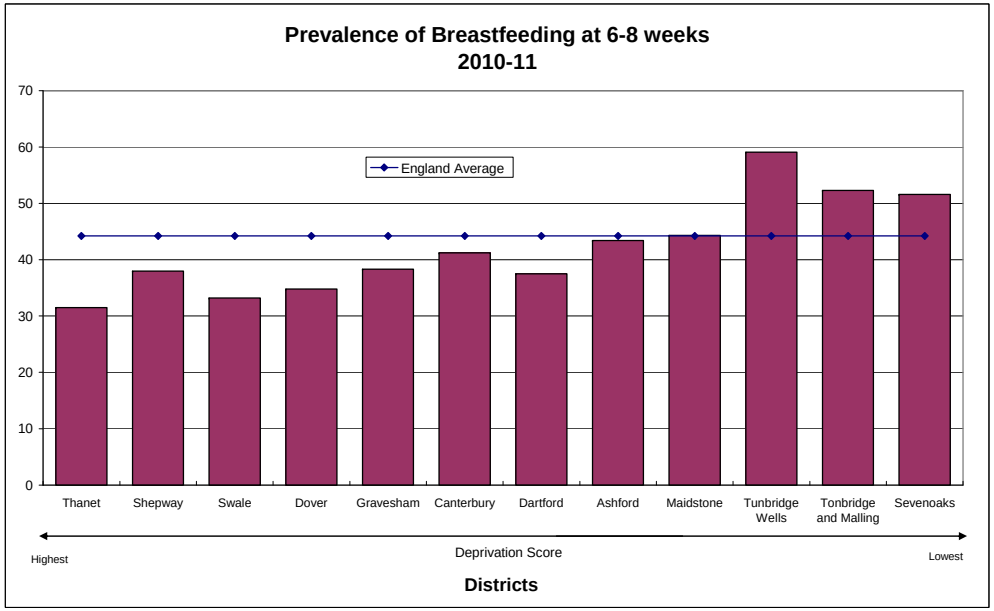
- The overall rate for infant mortality for Kent has been consistently lower than the England and Wales rate. However there are differences in infant mortality rates which could point to a health inequality based on socio- economic circumstances. There are a higher number of infant deaths in East Kent and latest data indicates that Dover far exceeds the Kent average.
- Low birth weight has serious consequences for health in later life. Increased viability and survival of very pre-term infants due to advances in medical technology will account for some of the very low birth rate weights.
- Smoking in pregnancy is known to affect both birth weight and incidence of infant mortality and continues to impact on the health of a child.
- Domestic violence is more likely to occur to women in their reproductive years, from lower socio-economic areas and often increases during pregnancy.
- A particularly vulnerable group is teenage mothers who are much more likely to be posing considerable risk to both themselves and their babies. They are also highly likely to access services late, potentially further compromising their care. Teenage mothers had a statistically significant higher rate of stillbirths. Postnatally they had much lower rates of breastfeeding at both birth and at 6-8 weeks.

Priority 1a.2 Support infant feeding by achieving UNICEF's Baby Friendly accreditation

Breastfeeding makes an important contribution to the health of mothers and infants. The Government has committed to increase support for breastfeeding as part of its strategy to reduce health inequalities and has set a target to increase breastfeeding initiation rates by 2% per year, focusing particularly on women from disadvantaged groups. In Kent averages in breastfeeding at birth mask significant disparity between Hospital Trusts. For example in two Kent hospitals from April- June 2011 65% of new mothers breastfed at the Darent Valley Hospital, 78% did so at Maidstone and Tunbridge Wells.
This translates to PCTs as:

Initiation Rates	Eastern and Coastal Kent	West Kent PCT	England Average
Breastfeeding at birth %	69.22	71.46	74.6

CHIMAT breastfeeding profile East & West Kent 2011 child profile- chimat



The rate of exclusive breastfeeding at birth and at 6-8 weeks confirms that women in the most deprived areas are less likely to breastfeed. The biggest drop off in breast feeding occurs by the fourth day after birth.

Local Profile

Setting Local Priorities: addressing inequalities at a district level. National target for coverage 95%. National target for prevalence 46%.

6-8 week breast feeding status by mother's Local Authority of residence 2011

Area	Number of Maternities	Prevalence of Breast feeding	% coverage The number of children with a breastfeeding status recorded as a percentage of all infants due for a 6–8 week check during the quarter
Ashford	1458	36.1%	83.2%
Canterbury	1475	38.8%	82.6%
Dover	1169	34.4%	87.6%
Shepway	1188	35.9%	87.4%
Swale	1715	27.9%	84.1%
Thanet	1667	31.1%	83.2%
Dartford	1436	33.4%	85.9%
Gravesham	1348	34.1%	87.2%
Maidstone	1969	42.1%	92.1%
Sevenoaks	1337	51.2%	90.1%
Tonbridge & Malling	1434	44.8%	92.0%
Tunbridge Wells	1395	54.1%	91.6%

Source: KMPHO

The Aspirations

Planners and Commissioners should
i) Use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.
ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively
iii) Assess impact on health inequalities by applying the Impact assessment tool

Action	What good will look like in 2015	Aspirational Targets
1a.1 Increase Numbers of Healthy Births		
All women are supported throughout their pregnancy, know how and when to access services and can easily find support in their community. They have access to help and information about avoidable risks and lifestyle choices to keep their baby healthy. Women in deprived areas or in at risk groups receive additional targeted support in ways that suit them and they access services in good time.		• Reduction in Infant mortality • 50% reduction in smoking in pregnancy by 2015 • 1% reduction in low birth weight
1a.1.1 Strengthen midwifery and Smoking Cessation resources to reduce smoking in pregnancy	Provide a whole systems approach to engaging with and supporting pregnant smokers. Linking pathways between acute, primary and community interventions.	• 50% reduction in smoking in pregnancy by 2015
1a.1.2 Strengthen midwifery resources to provide health buddy support through pregnancy	Giving priority to pre and post natal interventions including intensive home visiting with outreach to increase take-up from the most disadvantaged families Health buddy support -repeated broad based contacts with either a professional or peer educator both before and after birth to assist in take up of breast feeding and smoking cessation	
1a.1.3 Deliver effective campaign to promote good health and wellbeing in pregnancy	All women have access to good information and signposting to support lifestyle choices and wellbeing	
1a.1.4 Ensure teenage mothers have additional support	New ways of working: Children's Centres taking on the main role for providing tailored support to teenage parents including the facilitation of provision of specific education programmes within the young parent support groups. Commissioning of improved transition support onto longer term education and training programmes once input from young parent support groups has ceased.	For teenage mums- • 1% reduction in low birth weight • 75% Increase breast feeding initiation rates by 2015 • 55% Increase in breast feeding prevalence 6-8 weeks after birth by 2015

	Reduction in greater prevalence of smoking among teenage mums in areas of deprivation. Smoking cessation support is available in new non medical places targeted to where mums will go- soft play centres, libraries, children centres.	• Reduce greater prevalence of smoking amongst teenage Mums in areas of deprivation
1a.1.5 Support pregnant women who are experiencing domestic violence	Front line staff are given training and awareness raising about domestic violence, how to recognise it and what support is available. NICE Guidelines for women with complex social circumstances implemented	
1a.2 Increase breast-feeding initiation rates and prevalence at 6-8 weeks in all parts of Kent		
The Baby Friendly Initiative works with the health-care system to ensure a high standard of care for pregnant women and breastfeeding mothers and babies. In whatever way a woman chooses to feed her baby health care professionals will make sure mums are supported and confident The Kent and Medway Infant feeding plan will be fully implemented.		• 2% Increase breast feeding initiation rates • 2% Increase in breast feeding prevalence 6-8 weeks after birth
1a.2.1 Support infant feeding by achieving Unicef's Baby Friendly accreditation and by putting the infant feeding action plan in place	Working through maternity units, hospitals, children centres, midwives and Health Visitors to achieve Unicef's baby friendly accreditation. Best practice is in place in a range of medical and community settings and Unicef's assessment and accreditation process is in progress recognising those that have achieved the required standard There will be a quarter on quarter increase in the uptake of the Healthy Start scheme-a statutory scheme providing a nutritional safety net and encouragement for breastfeeding and healthy eating for pregnant women and children under 4 in low income and disadvantaged families across the UK.	
1a.2.2 Develop a needs assessment for breastfeeding to support targeting and commissioning of services	The needs assessment is being used to identify groups or areas where targeted support will increase breastfeeding	2% increase in breastfeeding rates in the most disadvantaged groups

Objective 1B: Give every child the best start in life (From 9 months)

Delivery through- Early Intervention and Prevention Programme; Healthy Child Programme; Healthy Schools; Putting Children First- Safeguarding and Looked After Children's Services Improvement and Development Plan; Action plan for children's emotional wellbeing and mental health; CYPP; Hidden Harm strategy ; smokefree homes initiative

Priorities	1b. 1 Support parents so that they can raise emotionally and mentally healthy children	1b.2 Encourage access to health services for all	1b.3 Promote Healthy Weight for Children	1b.4. Increase childhood immunisations in groups of children in whom uptake is identified as being below average
Actions	1b.1.1 Provide clear and quick access through a redesign of child and adolescent mental health services (CAMHS),	1b.2.1 Make Information available about finding and registering with a G.P. and dentist through community settings	1b.3.1 Implement new recommendations for physical activity for under 5s in early years settings	1b.4.1 increasing childhood immunisations among Gypsy and Traveller children
	1b.1.2 Targeted intervention through family nurse partnerships and commissioned support around High Need Families	1b.2.2 Families or young people who do not traditionally engage with services are supported to access health professionals	1b.3.2 Implement Healthy Weight Care pathway	1b.4.2 Introduce new ways and different settings to promote take up of childhood immunisations
	1b.1.3 Identify and improve access to services for substance misusing parents		1b.3.3 Support access to physical activity and sport into adolescence	
	1b.1.4 Targeted campaign to reduce children's exposure to secondhand smoke			

Objective 1B: Give every child the best start in life (9 months+)

Priority 1b.1 Support parents so that they can raise emotionally and mentally healthy children

The role parents play in the health and wellbeing of their children cannot be overstated. Assisting parents to make the right choices to support healthy outcomes is a key part of tackling health inequalities for young people. The county council and districts are uniquely placed to communicate with and support parents through children centres, schools, council services, libraries and Gateways. The Children's JSNA recommends that

- All agencies should target their approach to focusing on the **family** as a whole rather than children's behaviour
- Commissioning of services should recognise **home visiting** as a key intervention to addressing inter-generational improvements in parenting, child behaviour and cognitive development.

Priority 1b.2 Encourage access to health services for all

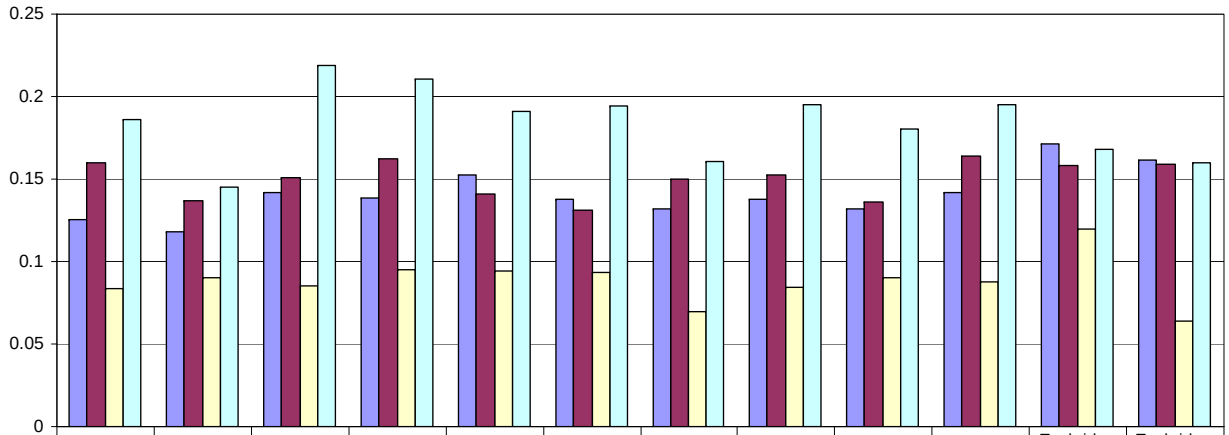
GP and Dentist registrations- access to health professionals is vital to support good health outcomes and finding and visiting a GP can be more difficult for those experiencing disruption in their lives- including looked after children and the homeless.

Priority 1b.3 Promote Healthy Weight for Children

Mounting evidence suggests that a critical period during which to prevent childhood obesity and its related consequences is before the age of five. The best thing we can do for children from 0-5 is create ways of life which continue to make obesity unlikely. Children who live in more deprived areas are more likely to be overweight and obese than those from the most affluent areas. Making what may seem like simple changes to daily habits (physical and nutritional) is sometimes simply too difficult given all the other difficulties many families have to confront.

Centre, Lifestyle Statistics / Department of Health Obesity Team NCMP Dataset

National Childhood Measurement Programme 2010/11: Percentage of overweight and obese children by year group and district



	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells
Reception Year: Overwieght	0.1256917	0.11817502	0.14148472	0.13880446	0.15280136	0.13739946	0.13185913	0.13793103	0.13178808	0.14185393	0.1712828	0.16140351
Year 6: Overweight	0.1601626	0.13656007	0.15077821	0.1626506	0.14080717	0.13108108	0.1500484	0.15285451	0.1362379	0.1637037	0.15847861	0.15911486
Reception Year: Obese	0.08379447	0.09050112	0.08558952	0.0952381	0.0942275	0.09316354	0.06961507	0.08429119	0.09006623	0.0877809	0.11953353	0.06403509
Year 6: Obese	0.18617886	0.14520311	0.2188716	0.21084337	0.19103139	0.19459459	0.160697	0.19521179	0.18049793	0.19481481	0.16798732	0.1601686

Priority 1b.4 Increase childhood immunisations

The national immunisation programme is an essential part of protecting children's health. Low vaccine uptake puts children at risk. Measles has made resurgence in the UK and the rate of take up of the MMR vaccine in Kent whilst improving, is not at the 95% level recorded by the World Health Organisation as being necessary to prevent an outbreak.

Percentage of children immunised by their 5th birthday 2010-11	DTP	Hib	DTPP	MMR	
	Primary %	Primary %	Booster %	First dose %	First and second dose %
West Kent PCT	93.7	94.9	91.4	92.3	87.4
Eastern & Coastal Kent PCT	96.3	96.7	90.1	93.5	87.0
England	94.7	94.2	85.9	91.9	84.2

Diphtheria Tetanus, Polio (DTP) Diphtheria Tetanus, Polio, Pertussis (DTPP) Mumps, Measles and Rubella (MMR). Information Centre 2011

Local Profile

Setting Local Priorities: addressing inequalities at a district level. Target 95% coverage rate of childhood MMR immunisations.

MMR immunisation rates for children by local authority* - 2010-2011			
Local Authority	**Number of children in cohort**	**Number of Children immunized against MMR by 5th birthday**	**Percentage of Children immunised against MMR by 5th birthday**
Ashford	1189	1030	86.6%
Canterbury	1631	1464	89.8%
Dartford	1323	1133	85.6%
Dover	1026	921	89.8%
Gravesham	1385	1246	90.0%
Maidstone	1758	1606	91.4%
Sevenoaks	1200	1048	87.3%
Shepway	1015	895	88.2%
Swale	1055	976	92.5%
Thanet	1324	1076	81.3%
Tonbridge & Malling	1560	1375	88.1%
Tunbridge Wells	1365	1213	88.9%
Kent	**15831**	**13983**	**88.3%**
*derived from child's registered GP practice: Source: CarePlus, Child Health System			

The Aspirations

Planners and Commissioners should

i) Use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.

ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively

iii) Assess impact on health inequalities by applying the Impact assessment tool

Action	What good will look like in 2015	Targets and achievements
1b. 1 Support parents so that they can raise emotionally and mentally healthy children		
All our children have a right to a good childhood and a positive future. Parents and carers will feel supported to bring up their children to be physically, mentally and emotionally healthy, to help them fulfill their potential and equip them to contribute to society. Services will offer targeted support to those families that are finding it hard to cope or face challenging situations.		
1b.1.1Provide clear and quick access through a redesign of child and adolescent mental health services (CAMHS)	CAMHS are easily accessible with short waiting times and improved access to psychological therapies Routine support to meet social need via outreach to families is available through schools, parenting programmes, children's centres and key workers	Access to and effective treatment from Camhs outcomes indicator
1b.1.2 Targeted intervention through family nurse partnerships and commissioned support around High Need Families	Family nurse prevention and the community budgets model are used to engage families in deprived areas or those facing additional challenges There is access to effective parenting programmes Children are ready for school and families are supported through the transition to school	Crude rate of hospital admissions caused by unintentional and deliberate injuries in age 0-17 per 100,00 resident population Childhood development at 2-2.5 years
1b.1.3 Identify and improve access to services for substance misusing parents	We will prioritise parents in specialist community treatment	Parents - % increase in the number of clients exiting treatment successfully Parents - % increase of new treatment journeys engaged in effective treatment (rolling year to end of quarter
1b.1.4 Targeted campaign to reduce children's exposure to secondhand smoke	Reduced amount of secondhand smoke that children are exposed to by making smoking outside the home the acceptable social norm amongst families who smoke; via A comprehensive and consistent approach across all partners to promote awareness of the damage caused by secondhand smoke to children.	Increased number of reported smokefree homes (especially amongst targeted groups)

1b.2 Encouraging access to health services for all		
1b.2.1 Information is available about finding a G.P. and dentist through community settings	Health Trainers making Information about finding a G.P. and dentist and how to register available at Gateways, Children's centres, schools and libraries. Health Trainers engaging with Gypsy and Travellers to increase numbers registered with GP & Dentist	• All Looked After Children (LAC) having an annual health check • Rate of tooth decay in children aged 5 years • Increasing immunisation to 95% rate
1b.2.2 Families or young people who do not traditionally engage with services are supported to access health professionals	Children and Young People from the following groups are able to get access to health services: • People with a learning disability • Looked after children • Homeless or in temporary accommodation • Gypsies and travellers	
1b.3 Promote Healthy Weight for Children		
Measures for early intervention should be targeted universally. Parents and carers are supported and informed in the early years about adopting good habits - how breast feeding and the introduction of good eating habits, physical activity and sleeping routines are likely to prevent the development of obesity. Children and young people have access to physical activity, sport at school and healthy food at school, affordable leisure activities and places to play.		From the 11/12 trend baseline we will aim to reduce the percentage increase in obesity from Reception year to year 6 by 1% per annum
1b.3.1 Implement new recommendations for physical activity for under 5s in early years settings	Healthy Schools Team working in new ways with early years settings and rolling out the effective early years pilot to areas of deprivation Once a child is mobile (under 5s) should be physically active daily for at least180 minutes spread throughout the day	
1b.3.2 Implement Healthy Weight Care pathway	Improved referral rates to programmes from health care professionals to family healthy weight programmes such as MEND	
1b.3.3 Provide access to physical activity and sport into adolescence for all	Continue to develop opportunities and programmes with partners and the 3rd Sector for young people to take part in sport – such as Sportivate and use the legacy of the 2012 Olympics and Para Olympics to promote the benefits of sport i.e. through the Kent school games Revise and promote the Active Kent website to provide information on local activities & services	http://www.kentsport.org/ http://www.activekent.co.uk/

1b.4 Increase childhood immunisations among most vulnerable groups		
New, non medical places will be promoting and offering immunisations with specialist targeting to groups with low take up rates		95% coverage of immunisations take up by age 5 in groups with low take up rates
1b.4.1 Increasing childhood immunisations among Gypsy and Traveller children		
1b.4.2 Introduce new ways and different settings to promote take up of childhood immunisations	• Promoting take-up in children's centres • Start in school programme as part of primary school registration in most deprived areas • Targeted Opportunistic Vaccinations for children presenting at A& E	

2. Enable All Children, Young People and Adults to Maximise Their Capabilities and Have Control Over Their Lives

Central to our vision is the full development of people's capabilities across the social gradient.
Without life skills and readiness for work, as well as educational achievement, young people will not be able to fulfil their full potential, to flourish and take control over their lives
(Marmot review 2010)

Life-Course 2: Key Priority for Making a Difference in Kent
Roll out Total Child Pilot to schools to help schools identify health and wellbeing issues pupils

Objective 2: Enable all children, young people and adults to maximise their capabilities and have control over their lives

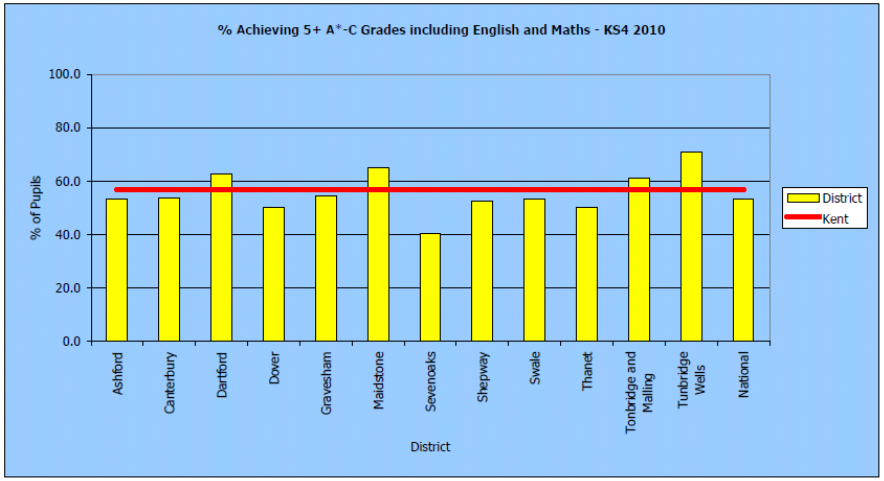
Delivery through – Kent Teenage Pregnancy Strategy; Adult Social Care Transformation Programme; 14-24 Strategy; Primary and Secondary Improvement Strategy; Youth Justice Plan; Anti-social behaviour Strategy; CYPP; Falls Strategy; Active Lives Now; Valuing People Now

Priorities	2.1 Improve educational attainment particularly at GCSE level	2.2 Reduce risk taking behaviours in young people	2.3 Support older people to live safe, independent and fulfilled lives and support disabled people to live independently at home
Actions	2.1.1 Roll out Total Child Pilot to schools to help schools identify health and wellbeing issues pupils are dealing with to target interventions to help narrow the gap. – **Priority issue for Kent**	2.2.1 Reduce teenage conceptions	2.3.1 Support self management of long term conditions
	2.1.2 To maximise children's attainment and development by improving housing conditions	2.2.2 De-normalise attitudes of smoking among young people	2.3.2 Deliver effective local services for falls, falls prevention and fractures
		2.2.3 Improve sexual health	2.3.2 Provision of adaptations and equipment to the home to prevent accidents with associated costs, and improve quality of life of recipients and carers
		2.2.4 Reduce risk taking behaviour in vulnerable groups including tackling the harmful affects of alcohol	2.3.3 Support people with Learning Disabilities with housing, employment, access to health services and leisure activities

Objective 2: Enable all children, young people and adults to maximise their capabilities & have control over their lives

Priority 2.1 Improve educational attainment particularly at GCSE level

There is a clear relationship between low educational attainment and poor health over a lifecourse. For young people educational attainment supports economic wellbeing- the ability to get and keep a job which indicates better mental wellbeing and health outcomes for the rest of their lives.
In 2009-10 GCSE statistics showed that around a third of pupils who had been receiving free school meals in the previous six years achieved five or more A*- C grades, compared to more than two thirds of their fellow pupils. In Kent, children who take free school meals experience marked inequality in comparison to the achievement of their peers- including significantly lower outcomes at GCSE. Those children achieving 5+ A*-C GCSEs are more likely to experience longer term employment and have the capability to retrain at least twice during a working life.

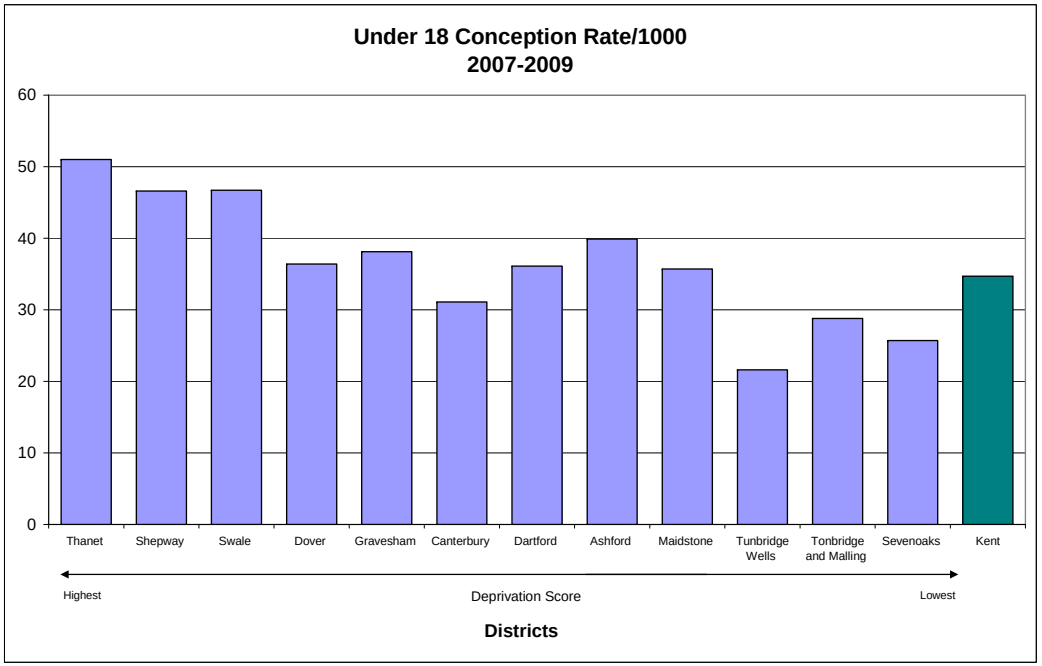


At present, the data derived from Department of Education returns reveal that Kent's position is currently good. 64.8% of children receive a good level of development at age five compared to the England average (58.8% and is also significantly better than the region as a whole (61.1%)

Whilst schools serving areas with significant concentrations of relative deprivation mainly do well against the England average they struggle to match the outcomes of the most affluent areas.

Priority 2.2 Reduce risk taking behaviours in young people

Teenage mothers and their children face particular inequalities. The link with a lack of aspiration is significant, young people need the motivation as well as the means to prevent pregnancy and engagement in education through the teenage years is a strong protective factor. Kent Teenage Pregnancy Strategy has mainstreamed much of the work needed to continue to reduce teenage pregnancy rates in Kent. There is evidence to show that providers of services to adolescents need to continue to focus on ensuring good quality information, advice and guidance on relationships, sex and contraception is available to those who need it including those who are most vulnerable and that schools and colleges need to ensure that girls and young women with poor academic achievement receive an educational offer which they find to be relevant and engaging.



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.

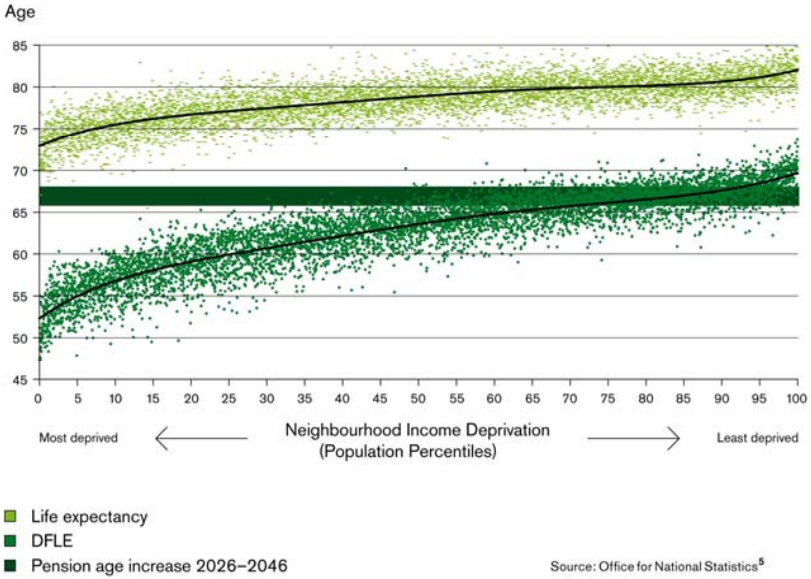
There is however significant difference in progress to reduce rates across the districts of Kent, with Canterbury having achieved the best reduction of 19% while Maidstone has demonstrated an increase of 10%.

(To avoid annual fluctuations rates are calculated on three year rolling averages.)

Sexual health: Sexually transmitted infections particularly affect young people and 15 to 24 year olds, particularly young women, continue to be the group most affected by sexually transmitted infections (STIs) in the UK or the group that most present for treatment. Untreated infection can lead to serious health problems, including infertility. Acute STIs diagnosed between 1998 and 2009, increased by 100% in the east Kent and west Kent clinics. Late diagnosis of HIV is a problem in some areas of Kent, for example almost 55% of HIV diagnoses in West Kent are classified as late diagnosis.

Priority 2.3 Support older and disabled people to live independently

Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003



Source: Office for National Statistics[5]

Inequality in Disability Free Life Expectancy (DFLE)

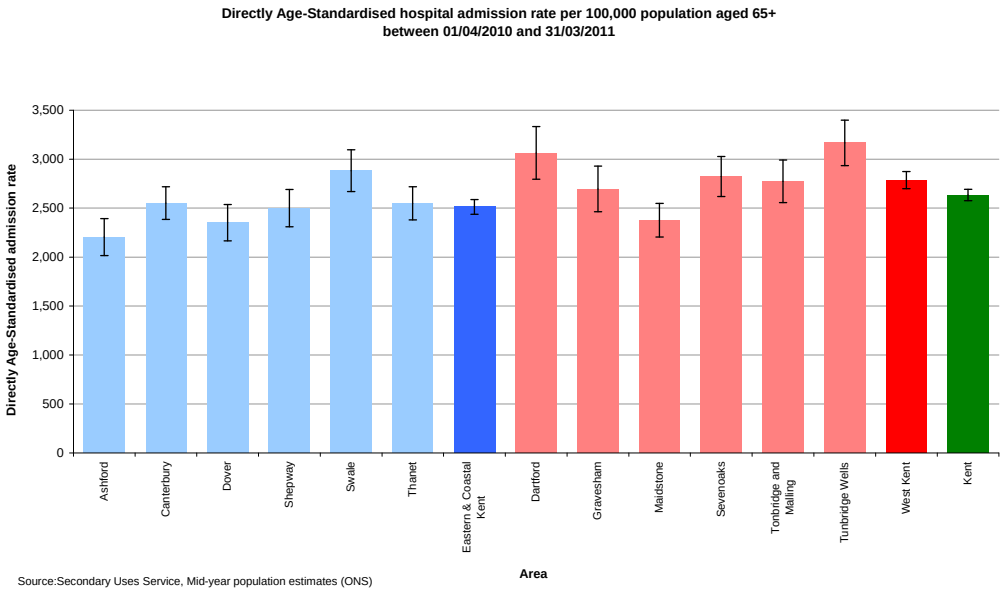
DFLE is the average number of years a person could expect to live without an illness or health problem that limits their daily activities. For males the Kent figure is 11.4 years difference. This is worse than the England value (10.9). It is also significantly poorer than the regional value of 8.9years. For females, the Kent figure is 9 years difference. This is marginally worse than the England figure (9.2 years) but significantly poorer than the regional average (7 years).

Long Term Conditions

- Older people with multiple long term conditions are the main driver of cost and activity in the NHS as they account for around 70% of overall health and social care spend.
- They are disproportionately higher users of health services – representing 50% of GP appointments, 64% of outpatient attendances, 70% of inpatient bed days, 58% of A&E attendances and 59% of practice nurse appointments.
- The average cost per year of someone without a long term condition is around £1,000 which rises to £3,000 for someone with one condition and to £8,000 for people with 3 or more conditions.
- Patients universally say that they wish to be treated as a whole person and for health and social care services to act as one team. Despite this, those people who have more than one condition, particularly older people, face an increasingly fragmented response.
- The following principles have been agreed as national LTC model of care:
- Using validated risk profiling to support commissioners to understand the needs of their population and manage those at risk to prevent disease progression and allow for interventions to be targeted and prioritised.
- Integrated health and social care teams based around a locality (or neighbourhood) to provide joined up and personalised services to treat patients holistically.

- Empowering patients to maximise self-care, self-management and choice, through shared decision making and motivational interviewing, for example use of appropriate assistive technologies.

Falls and Fractures



Source:Secondary Uses Service, Mid-year population estimates (ONS)

Falls and fractures are a major cause of disability and the leading cause of mortality due to injury in older people aged over 65 in the UK, with large implications for the quality of life of older people who survive a fall.

Hip fracture is the most serious injury related to falls in older people, and can lead to loss of mobility and loss of independence, forcing many to leave their homes and move into residential care. Mortality after hip fracture is high: around 30% after one year. Current specialist services, particularly in West Kent, are not adequately resourced enough to risk assess all fallers (early enough) and provide or refer them to suitable interventions such as community exercise, adaptations at home and assistive technologies like telecare.

The lack of timely specialist risk assessment represents an important inequity in service leading to health inequalities both geographically as well as by age. For example the graph above suggests higher falls admission rates in West Kent compared to East Kent because of the lack of suitable specialist services in the hospital and community to deal with at risk fallers.

CCGs therefore need to commission the expansion and integration (with acute trust, social services and other partner organisations) of existing community rehabilitation teams particularly in West Kent to provide comprehensive timely falls and / or fracture risk assessments to elderly fallers who are seen by ambulance and A&E services

Support for People with a Learning Disability

People with learning disabilities have poorer health than their non-disabled peers. These differences are to an extent avoidable, and as such represent health inequalities. The impact of these inequalities is serious. The research indicates that people with moderate to severe learning disabilities are three times as likely to die early than the general population.
Improving Health and Lives – implications for social care commissioning and practice: A discussion paper Sue Turner September 2011

People with learning disabilities have a wide range of social and health care needs. This reflects the spectrum of severity for learning disabilities and the different conditions that may co-exist. People with learning disabilities also have needs generated by social exclusion, such as poverty, lack of housing and unemployment. Those with mild learning disabilities may need specialist support in mainstream education while they are children. Subsequently, they may need the same support/benefits as others in socially excluded groups, rather than specialist services. At higher levels of disability, however, many individuals will have lifelong needs for health and social care.

The Joint Strategic Needs Assessment identifies that people with a learning disability in Kent are more likely to be obese, have dementia, mental health problems, physical disability, sight and hearing impairments than the general population.
They are less likely to access general health services resulting in low rates of health screening take up and poorer dental health. They often have communication difficulties or impairment of social ability. In 2007 46,700 people in Kent were believed to have a learning disability, 42,000 persons with a moderate learning disability and approximately 4,700 with a severe learning disability. Only a small proportion of these are in contact with Social Care Services. Having a learning disability can lead to restriction in participation in society- not only for the person with a disability but also their families and carers.

Local Profile

Setting Local Priorities: addressing inequalities within Districts

	Implementation of Total Child to identify health and wellbeing issues
Ashford	√ (7 Schools)
Canterbury	√ (1)
Dartford	√ (5)
Dover	
Gravesham	√ (1)
Maidstone	√ (2)
Sevenoaks	
Shepway	√ (7)
Swale	
Thanet	√ (3)
Tonbridge & Malling	√ (4)
Tunbridge Wells	√ (3)

The Aspirations

Planners and Commissioners should
i) Use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.
ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively
iii) Assess impact on health inequalities by applying the Impact assessment tool

Action	What Good Will Look like in 2015	Targets and achievements
2.1 Improve educational attainment particularly at GCSE level		
2.1.1 Roll out Total Child Pilot to schools to help schools identify health and wellbeing issues pupils are dealing with to target interventions to help narrow the gap.	• Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education • Consistently implementing the full range of extended services in and around schools • Developing the school-based workforce to build their skills in working across school– home boundaries and addressing social and emotional development, physical and mental health and well-being.	• Narrowing the gap between pupils on free school meals and their peers achieving 5* A-C • Narrowing the gap between achievement across Districts
2.1.2 To maximise children's attainment and development by improving housing conditions	• Children's Centres to liaise with the local housing authority regarding any concerns with the children's housing conditions. • Develop a single point referral system to health related services across Kent for all key agencies involved in Children's Services, for example the Thanet system	The number of properties with children aged 9 months+ where housing action taken
2.2 Reduce Risk taking Behaviours in young people		
2.2.1 Continue to reduce teenage pregnancies	• Health services are young people friendly and accessible • Children's Centres have a relevant offer for all very young parents which helps them to access education as well as providing care for their child/ren • All providers of services to adolescents screen for and engage in preventative work to reduce risk taking behaviours • The most vulnerable groups receive effective outreach services	• Reduce rate of teenage conceptions in all districts to less than 40 per 1,000 by 2015 • No of GPs with You're Welcome Standard
2.2.2 De-normalise attitudes and halt uptake of smoking among young people	• Kent schools to adopt a comprehensive tobacco education programme that meets individual school's needs. Develop a youth advocacy campaign which empowers young people with a wider knowledge base about all tobacco control issues and capitalises on their energy and enthusiasm.	• Reduce smoking prevalence rates among under 15 year olds • Reduce illicit tobacco and supply of tobacco to under 18s
2.2.3 Improve sexual health by reducing late diagnosis of HIV in Kent and increase Chlamydia screening	A range of targeted work will increase HIV testing • For Black African women • Through MSM to increase early testing • in high prevalence areas in Kent Health care professionals will receive training to broach the topic of risk factors for STIs and work to increase Chlamydia screening in poor performing areas	• Reduction in late diagnosis of HIV by 1% • Increase in take up of Chlamydia screening in • Primary care • In partners • In young males

2.2.4 Reduce risk taking behaviour in vulnerable groups including tackling the harmful affects of alcohol	Targeted work focused on young people who have complex or multiple needs- i.e. they are looked after, young offenders, have a mental health problem, are substance or alcohol misusers	• Reduction in risk taking behaviour in vulnerable groups • Penetration of early intervention services into populations of vulnerable young people • 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
2.3 Support older or disabled people to live independently		
2.3.1 Support self management of long term conditions	• Risk Profiling – All CCGs have agreed and are using a common approach towards identifying individuals at high risk requiring complex care by using risk prediction tools and electronic searches applied to local health and social care datasets and sharing this (real time) information with those who need it so that care can be pro active, moving from a treatment system to a preventive system. CCGs will also ensure clinical access to real time urgent care data sources in a combined dashboard. • CCGs will have implemented effective primary / community / secondary / social care infrastructures including single point of access and target those identified at high risk then tailor their care through a case /care management / holistic approach using neighbourhood health and social teams. • CCGs will have implemented a shared decision making process with patients such as negotiated agenda setting, information sharing, supporting autonomy, supporting goal setting and action planning. Priority should be given to empowerment of patients to self manage their conditions with support from carers and families.	• Increase in proportion of elderly living independently in their own home • Reduction in demand for residential care / nursing home admissions including admissions direct from hospital • Increase in number and use of personalised care management plans linking into integrated personal budgets • Reduction in admissions to residential / nursing care • Reduction in emergency admissions (up to 20%) • Reduction in emergency bed days (up to 25%) • Reduction in proportion of inappropriate admissions (from current 9%) and inappropriate hospital bed days where no acute care was given (from current 50%) (as measured by Utilisation Review of hospital beds)

2.3.2 Deliver effective local services for falls, falls prevention and fractures	• Development of integrated falls and fracture prevention services by existing intermediate care / rehab teams (in KCHT) and geriatricians (from acute trusts) with support and partnership from other organisations i.e. GPs, ambulance, adult social services, district councils, community pharmacists and voluntary organisations. This is needed more in West Kent than East Kent. • Ensure risk assessment is carried out as early as possible by targeting fallers non conveyed to A&E (by ambulance), and fallers conveyed to and discharged from A&E (but not admitted). • Community based therapeutic exercise programmes (postural stability) run by voluntary organisations or district authorities for elderly fallers who are formally assessed, referred and followed up by the Falls preventions services mentioned above. • Industrialise use of assistive technologies and adaptations such as telecare and telehealth to support people at home who have been formally risk assessed by Falls Prevention Service. Use of Disabled Facilities Grant.	• Reduction in the proportion and number of ambulance callouts related to falls in the > 65 yrs age group. • Reduction in the proportion and number of falls related admissions including fractures in the >65 yrs age group.
2.3.3 Provision of adaptations and equipment to the home to prevent accidents with associated costs, and improve quality of life of recipients and carers	Improved joint working and timely delivery of adaptations though the Disabled Facilities Grant. Telehealth and telecare considered automatically in this process	
2.3.4 Support people with Learning Disabilities with housing, employment, access to health services and leisure activities	Valuing People Now Partnership continues to work towards • ensuring people have more choice and control over what they do during the day • they do not feel excluded from the wider community and its opportunities • finding ways to help people with learning disabilities get real jobs • making it easier to get better housing with appropriate levels of support; • Advocacy is available so that people can communicate their wishes	

3. **Create fair employment & good work for all**

The recession is leading to increasing unemployment across Kent. Marmot says that work is good – and unemployment bad – for physical and mental health.

However the quality of work is also important with underlying low levels of stress connected to low paid and insecure work in poor conditions contributing to poorer health outcomes. Work cannot provide a sustainable route out of poverty if job security, low pay and lack of progression are not also addressed

Life-Course 3: Key Priority for Making a Difference in Kent
Increase proportion of Young People (16-18) & (18-24) in full time education or employment

Objective 3: Create fair employment & good work for all

Priorities

Delivery through Regeneration strategy; Backing Kent Businesses; 14-24 Strategy; Employability Strategy

Actions

3.1 Improve chances of employment for people facing disadvantage- carers, lone parents, those with learning or physical disabilities or mental health problems	3.2 Increase proportion of Young People (16-18) & (18-24) in full time education or employment **- Key Priority for Kent**	3.3 Support business to have healthy workplaces
3.1.1 Job clubs in children's centres and other places (Gateway, Healthy Living Centres)	3.2.1 Kent Community programme/ apprenticeships	3.3.1 Healthy workplaces initiative
3.1.2 Create and develop opportunities and initiatives that support vulnerable people into work	3.2.2 Readiness for work	3.3.2 Work with employers to support mental health and wellbeing of their workforce
		3.3.3 Reduce Smoking prevalence among routine/manual workers through Kent Smokefree Business Awards
		3.3.4 Work with Kent businesses to enable them to cut costs and reduce their environmental impacts.

Objective 3: Create fair employment & good work for all

Priority 3.1 Improve chances of employment for people facing disadvantage- carers, lone parents, those with learning or physical disabilities or mental health problems

Disabled workers, those with low or no qualifications and lone parents are among the groups of people most likely to find themselves long-term unemployed. (Begum 2004) With fewer jobs available it is likely that unemployment rates for all vulnerable groups will increase- causing an increase in demand for support from Health, Welfare and Social Care services

Adults with mental health problems employed:	Eastern and Coastal Kent	West Kent PCT	England Average
% of adults with mental health problems aged 18-69 in contact with secondary mental health services who were known to be in paid employment at the time of their assessment or latest review. 2009	5.2%	5.8%	7.9%

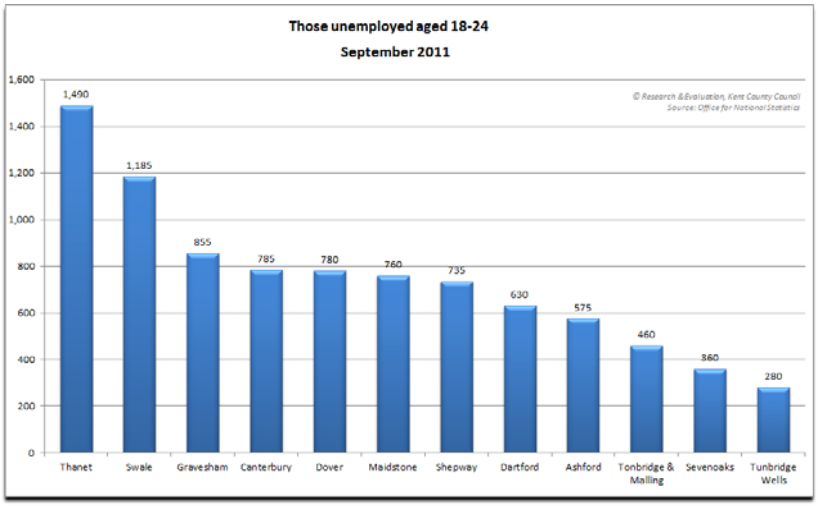
The employment rate for people who are disabled in the KCC area is 51.9%. This is lower than the employment rate for people without a disability which is 78.4% in the KCC area. This is below the South East average rate of 55.7% but above the national average rate of 48.8%.

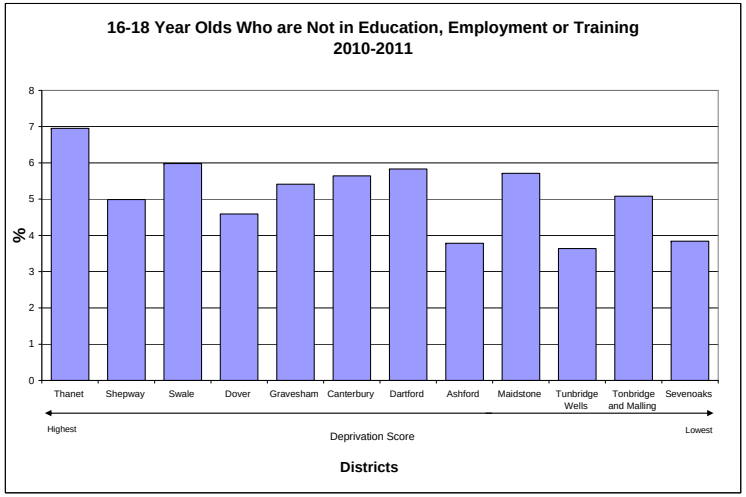
The difference in employment rates also varies across the KCC area. In Ashford the employment rate for people with a disability is 69.0% and for those without the rate is 79.3%, however in Thanet only 42.2% of disabled people are in employment as opposed to 80.0% of people without a disability.

As of May 2011 nearly 34,000 lone parents were claiming income support. (11,000 men, 22,000 women) Benefit reforms are expected to have the most impact on unemployed, lone, female parents causing them to be worse off financially.

Priority 3.2 Increase proportion of Young People (16-18) & (18-24) in full time education or employment

Young people continue to be disproportionately affected by the economic downturn with those aged 18-24 making up the biggest proportion of unemployed in the KCC area. Again areas of deprivation are experiencing the biggest impact and the social gradient can be clearly demonstrated





Research has shown that being not in employment, education or training (NEET) between the ages of 16 and 18 is a major predictor of future unemployment, low income, teenage parenting and poor health. Young people who are NEET are also 5 times more likely to enter the criminal justice system, with the life-time cost to the state of each young person who is NEET standing at £97,000.

Latest figures show that numbers of NEETS in Kent are increasing. In Kent the position is 5.9% of young people not in employment, education or training. In England the percentage is 6.7% and the regional position is 6.1%. Performance varies across Districts, with Thanet, Maidstone, Swale and Shepway historically having higher numbers of NEET (16-18). Young people with special educational needs (SEN), offending behaviour, and health issues, teenage mothers and looked after children (LAC) all perform poorly in comparison with their peers.

Local Profile

Setting Local Priorities: addressing inequalities within Districts

The percentage of 16 to 18 year olds who are not in education, employment or training (NEET)

	2010-2011
Ashford	3.8
Canterbury	5.6
Dartford	5.8
Dover	4.6
Gravesham	5.4
Maidstone	5.7
Sevenoaks	3.8
Shepway	5.0
Swale	6.0
Thanet	7.0
Tonbridge & Malling	5.1
Tunbridge Wells	3.6
Kent	4.9

The Aspirations

Planners and Commissioners should

i) Use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.

ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively

iii) Assess impact on health inequalities by applying the Impact assessment tool

Action	What Good will look like in 2015	Targets and achievements
3.1 Improve chances of employment for people facing disadvantage- carers, lone parents, those with disabilities or mental health problems		
3.1.1 Job clubs in children's centres and other places (Gateways, Healthy Living Centres)	Employers have been encouraged/ incentivised to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems	Employment of people with long term conditions
3.1.2 Create and develop opportunities and initiatives that support vulnerable people into work	• Maximise opportunities to support people into work through initiatives such as o Kent Supporting People o Kent Supported Employment • Support development of Social Enterprises with the voluntary sector	Employment of people with mental health problems

	• Work with employers and service users to support sustainable employment for people with mental health problems	
3.2 Increase proportion of Young People (16-18) & (18-24) in full time education or employment		
3.2.1 Kent Community programme/ apprenticeships	Supporting vulnerable learners into apprenticeships	Year on year reduction in NEETs
3.2.2 Readiness for work	Partners have worked with employers to gain an understanding of what skills the employers of Kent want and educational settings have come together to ensure training, work opportunities or further education is targeted to these skills Providing support and advice for 16–25 year olds on life skills, training and employment opportunities, delivered through centres that are easily accessible to young people Development of employability programmes and progression pilots that focus on vulnerable learners.	Rate of young people who are NEETs
3.3 Support business to have healthy workplaces		
3.3.1 Healthy workplaces initiative		
3.3.2 Work with employers to support mental health and wellbeing of their workforce	Wellbeing of staff is a priority, especially in the context where many are being made redundant and workloads are increasing.	
3.3.3 Reduce Smoking prevalence among routine/manual workers through Kent Smokefree Business Awards	Provide organisations with an economic assessment of the cost of smoking to their organisation, and support the development of comprehensive smokefree policies (promoting wellbeing for staff and adherence to smokefree legislation). The scheme will reward organisations and ensure relationships are forged with the Stop Smoking Services. (see also section 6.2.3)	Reduction in smoking prevalence of routine and manual workers
3.3.4 Work with Kent businesses to enable them to cut costs and reduce their environmental impacts		

4: Ensure healthy standard of living for all

Having insufficient money to lead a healthy life is a highly significant cause of health inequalities

(Marmot Review 2010)

Life-Course 4: Key Priority for Making a Difference in Kent
Reduction in the levels of inequalities for Life Expectancy for Males and Females

Objective 4: Ensure healthy standard of living for all

Delivery through Backing Kent People Programme; District Community Strategies; CYPP
Kent's Poverty Strategy

Priorities

- 4.1 Support financial capacity and inclusion
- 4.2 Promote opportunities to support families in poverty

Actions

- 4.1.1 Continue to promote Kent Credit Savers Union to enable people to smooth their incomes and have access to affordable credit
- 4.1.2 Provide financial advice as to how best to manage debts and household budgets in general.
- 4.1.3 Campaigns to highlight the pitfalls of doorstep lending and loan sharks
- 4.2.1 Access to free or affordable childcare places to help people work
- 4.2.2 Enable Kent Population to access information and advice about benefits and available financial support in places where they go
- 4.2.3 Provide information and signposting for older people who may be struggling to heat their homes

Objective 4: Ensure healthy standard of living for all

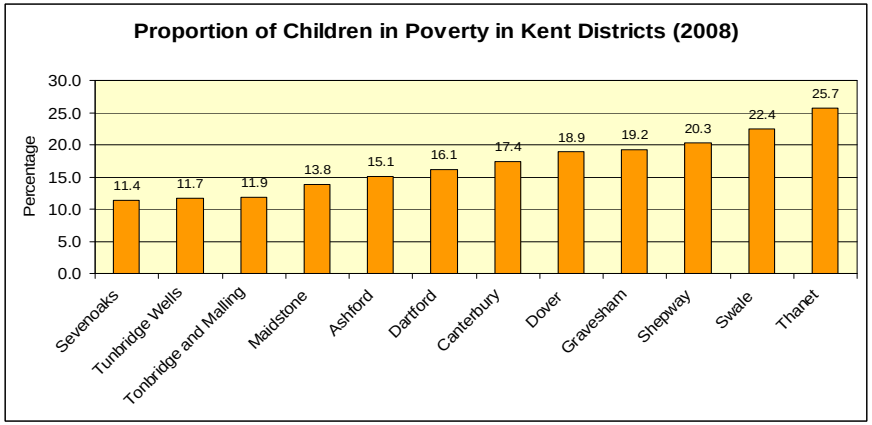
Financial security is recognised within the Marmot Review as a social determinant of health, specifically through the concept of the 'social safety net'. The nationwide Health Survey 2010 identified that for both men and women well-being increased with household income. Those on the highest income level scored more than five points higher than those on the lowest income level according to the Warwick-Edinburgh Mental Well-being Scale.
Deprivation is associated with a cluster of health problems including higher levels of unhealthy weight and obesity, physical inactivity, smoking, poor blood pressure control, and other factors that effect physical health. It is also integral to lower educational attainment, lack of employment opportunities, poor housing status, poor access to services, referral differences of practitioners and poor compliance with disease management

Priority 4.1 Support financial capacity and inclusion

This is particularly relevant now when greater financial responsibility and engagement is being asked of people, whether that is managing care needs in retirement or managing personalised health and social care budgets.
A credit union provides access to fair and affordable credit that allows people to smooth peaks and troughs of income. Conversely, overindebtedness is causing real misery for households and communities. 8 in 10 financially excluded individuals live in social housing.

Poor financial skills can result in debt:
"It is due to negligence on my part and not having enough experience of handling money when I moved out of my parents' home."
from A Life in Debt- The profile of CAB debt clients in 2008

Priority 4.2 Promote opportunities to support families in poverty



The most recent data available at a local level is for child poverty in 2008. This shows 17% of children living in Kent as living in poverty, compared to a national figure of 21%, and equates to over 53,000 children. Within Kent there is considerable variation across districts ranging from 11% in Sevenoaks to 26% in Thanet.

Childcare availability, cost and quality, can be an issue for parents, particularly those of young children. Cost can make low-paid work financially unviable; care is also sometimes not flexible enough, with parents unable to find care for evenings, weekends, at short notice, and in school holidays. In Kent it is estimated that a total of 4,409 additional childcare places are required across Kent and the most significant need for additional places occur within the most deprived areas of Kent.

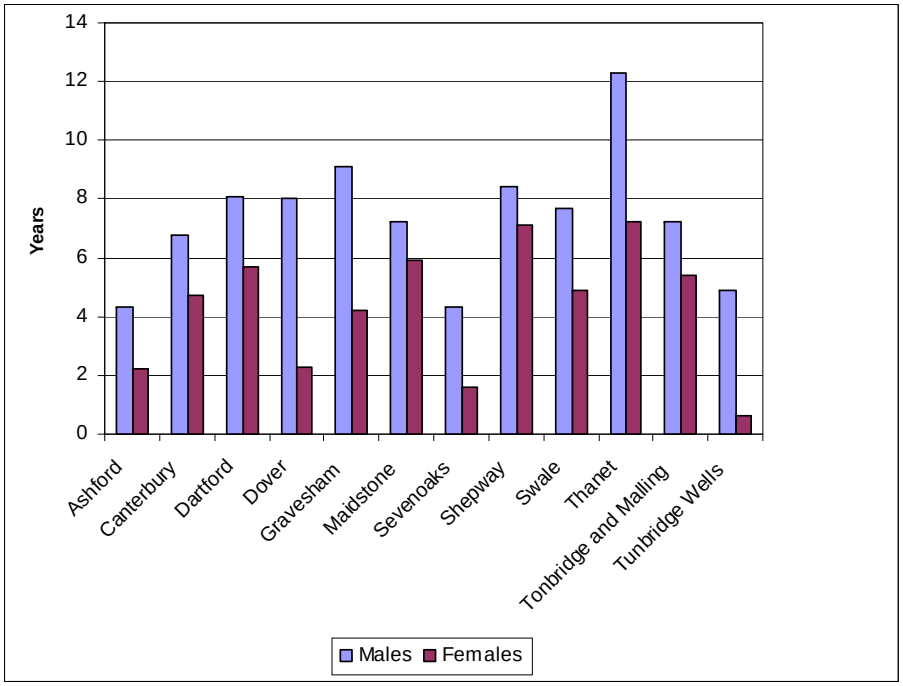
Local Profile

Setting Local Priorities: addressing inequalities within Districts

Table and Chart Showing Slope Index of Inequality for Life Expectancy by Deprivation Deciles – 2005-09

	Males	Females
	Slope Index of Inequality (years)	Slope Index of Inequality (years)
Kent CC	8.1	5.0
Ashford	4.3	2.2
Canterbury	6.8	4.7
Dartford	8.1	5.7
Dover	8.0	2.3
Gravesham	9.1	4.2
Maidstone	7.2	5.9
Sevenoaks	4.3	1.6
Shepway	8.4	7.1
Swale	7.7	4.9
Thanet	12.3	7.2
Tonbridge and Malling	7.2	5.4
Tunbridge Wells	4.9	0.6

Source: APHO 2011



Slope Index score represents the gap in years of life expectancy at birth between the most deprived and least deprived in the local authority area.

The Aspirations
Planners and Commissioners should
i) Use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.
ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively
iii) Assess impact on health inequalities by applying the Impact assessment tool

Action	What Good will look like in 2015	Targets and achievements
4.1 Support financial capacity and inclusion		
4.1.1 Continue to promote Kent Credit Savers Union - Kent's credit Union, to enable people to smooth their incomes and have access to affordable credit	Kent credit union is being used by local people with regular promotions to everyone in the County.	
4.1.2 Provide financial advice as to how best to manage debts and household budgets in general	Money management for Vulnerable Young people extended from schools to HOUSE & Youth Hubs – possibly delivered by Healthy Schools Team. Continue to provide free hosting for CAB at Gateways	
4.1.3 Campaigns to highlight the pitfalls of doorstep lending and loan sharks	Signposting, advice and guidance available from kent.gov.uk and partners sites.	
4.2 Promote opportunities to support families in poverty (support implementation of Kent's family poverty strategy)		
4.2.1 Access to free or affordable childcare places to help people work	Increase in affordable child care places	Reduction of number of children in poverty
4.2.2 Enable Kent Population to access information and advice about benefits and available financial support in places where they go		
4.2.3 Provide information and signposting for older people who may be struggling to heat their homes	Keep Warm in Winter campaign signposting to benefits and energy saving measures	

5. Create and Develop Healthy and Sustainable Places & Communities

Dream with me of a fairer world, but let us take the pragmatic steps necessary to achieve it

Sir Michael Marmot October 2011

Life-Course 5: Key Priority for Making a Difference in Kent
Reduce homelessness and its negative impact for those living in temporary accommodation

Objective 5: Create and Develop Healthy and Sustainable Places & Communities

Find ways to integrate planning, transport, housing, environmental and health policies to address the social determinants of health in each locality. Delivery through Kent housing strategy, Supporting people, Regeneration strategy; District Community Strategies; Keep Warm Keep Well and Warm Homes Healthy people

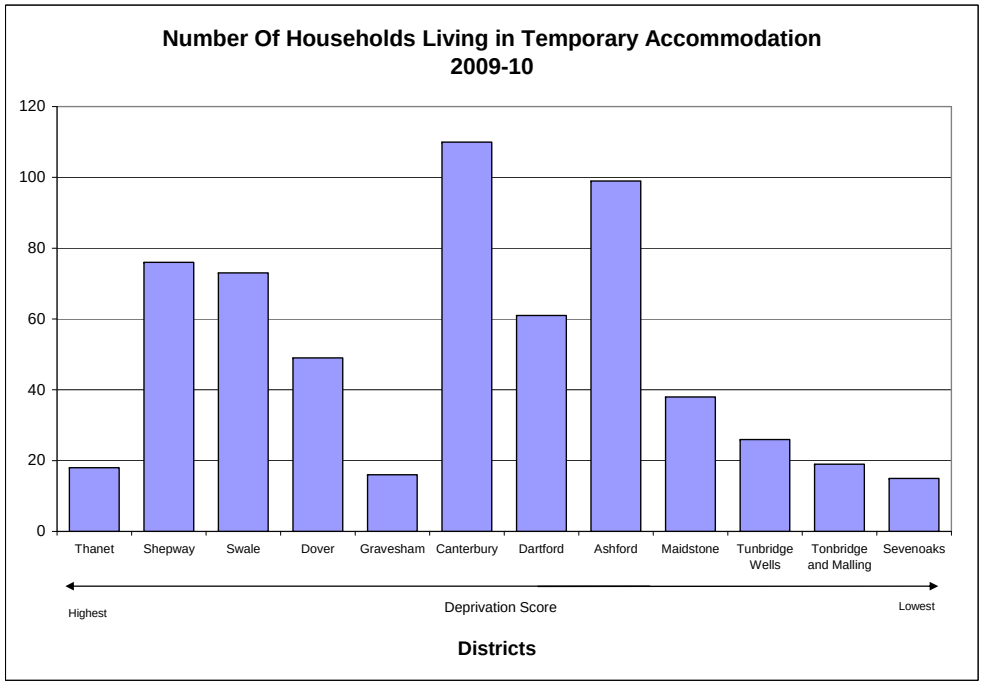
Priorities	5.1 Reduce homelessness and its negative impact for those living in temporary accommodation **- Key Priority for Kent**	5.2 Develop our communities to be healthy places	5.3 Support safe communities	5.4 Reduce Fuel Poverty by supporting development of warm homes
Actions	5.1.1 Enable and support a young person aged 16/17 at risk of homelessness to remain within or return to a family network wherever possible and appropriate	5.2.1 Rollout initiatives such as House and ACTIV Mobs that help to develop community capacity and sustain positive community outlook.	5.3.1 Working with Fire Service and local housing authority to target most vulnerable households to reduce risk of fire	5.4.1 Update, reissue and promote strategic tools that support the build of warm homes- Kent Health and Affordable Warmth Strategy and the Kent Design Guide
	5.1.2 Continuation of the Youth Homelessness Education Programme	5.2.2 Continue to support affordable ways for people to travel in the community	5.3.2 Reduce demand and supply of cheap and illicit tobacco in our communities	5.4.2 Local housing authorities will continue to ensure housing is decent and not subject to excess cold.
	5.1.3 Kent Housing Group and Public Health team will promote HI agenda with Housing Providers	5.2.3 Develop public rights of way, parks, green spaces and places to play	5.3.3 Reduce number of children and young people injured on the highway	
		5.2.4. Reduce the impact of poor housing on health be it physical or mental well being		
		5.2.5 Reduce air pollution		

Objective 5: Create and Develop Healthy and Sustainable Places & Communities

Promoting wellbeing is at the heart of what local government is about: supporting a better life for its citizens and helping to build resilient communities, now and over the longer term

Priority 5.1 Reduce homelessness and its negative impact for those living in temporary accommodation

- Changes to the welfare system are already impacting on people in London and this is leading to migration to surrounding counties, particularly Kent, putting additional pressure on housing and other resources.
- The number of households being made homeless is increasing in Kent due to the recession, rising unemployment and cost of living so that families are finding themselves unable to meet the cost of mortgages and rent. From April to June 2011 Kent local authorities made 588 decisions on applications for housing assistance. This is 43% higher than the same quarter in 2010. Of the 588 decisions 229 households were accepted as homeless, an increase of 13% compared to one year ago
- Districts have made significant improvements from more than 1,800 households living in temporary accommodation in 2004/05 to 583 in 2009/10
- Many homeless young people are placed in temporary accommodation, including Bed & Breakfast. Homeless young people are often very vulnerable, have multiple needs and are in need of support as well as accommodation. Most recent data shows that young people leaving care in Kent (2009-10 data) and young offenders (2008-9) are less likely to find suitable accommodation than is the case nationally and across our statistical neighbours



Shelter **Living in limbo:** Survey of homeless households living in temporary accommodation 2004

- Over half of people said that their health or their family's health had suffered due to living in temporary accommodation
- Children had missed an average of 55 school days due to the disruption of moves into and between temporary accommodation
- Two thirds of respondents said their children had problems at school; and nearly half described their children as 'often unhappy or depressed'
- Over three quarters of households (77 per cent) had no family member working. The reasons for this included health or mobility problems, the insecurity of their accommodation, high rents and worries about changes to benefits

Priority 5.2 Develop our communities to be healthy places

Within our county there are health inequalities that are differentiated geographically. Local authorities are the planning authorities for their areas and, as such, have huge opportunities to influence both the infrastructure and the services provided in an area.

Data for Kent shows that 20.5% of lower super output areas in Kent (181 small areas) are within England's most deprived 20% of areas; experiencing barriers to housing and services. This situation is made worse by the number of rural areas in Kent and that in general 20% of households cannot afford a car to access essential services such as GP, primary school, post office and supermarkets. Housing and transport can affect key opportunities to accessing fresh food, employment and maintaining social networks.

The effects of air pollution are distributed unequally within society, and widen the inequalities in health. Those populations at greater vulnerability to the effects of exposure to air pollutants are the young and elderly, those with pre-existing cardiopulmonary disease and those who live near or work with other toxic material. These groups tend to represent the socioeconomically deprived communities. Individuals closest to sources of air pollution (near busy roads) are likely to be from lower socioeconomic class and are at greatest risks from the effects of air pollution. Interventions to reduce air pollution may help reduce health inequalities. It is estimated that there are 963 excess deaths per year due to long term exposure, and 91 excess deaths per year due to short term exposure to air pollution in Kent and Medway.

Priority 5.3 Support safe communities

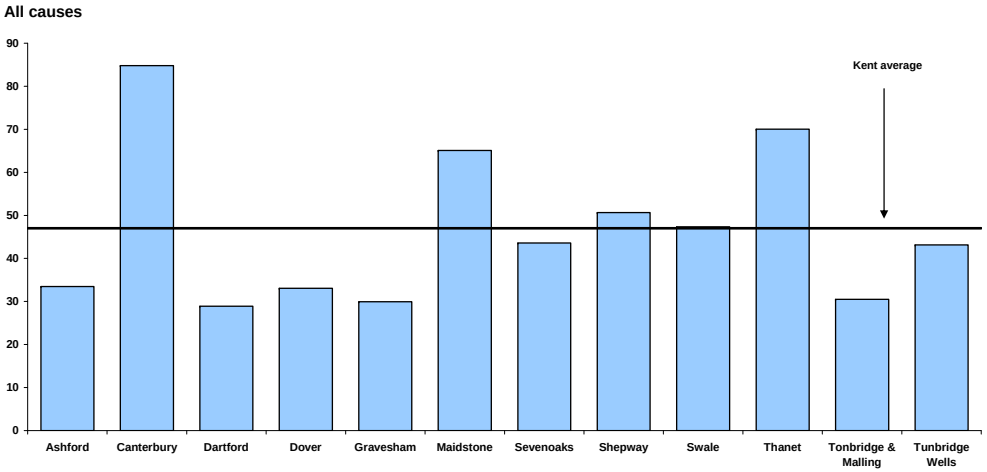
- Road Safety: Injury is not only most often the cause of child death in the UK, but also has a steeper social class gradient than any other cause of child death. Casualty rates for child pedestrians are estimated to be five times higher in the most affluent than least affluent wards (Social Exclusion Unit 2003). Traffic calming, design which encourages cycling and discourages car use and parking in the least affluent areas are all part of the contribution local government can make to improving health and reducing health inequalities.

- Fire Safety: In 2010-11 Kent Fire and rescue services attended 677 accidental dwelling fires. 2 people died and 77 people were injured as a result of accidental fires. In Kent there are on average 46 fires per year in households and household dwellings caused by smoking. This results in a total cost of £1,150,000 pa in Kent. A child from the lowest social class is nine times more likely to die in a house fire than a child from a well off home.

Priority 5.4 Reduce Fuel Poverty by supporting development of warm homes

Fuel poverty, is said to occur when people in a household need to spend more than 10 percent of their income total in order to heat their home. 6% of households in the KCC area are estimated to be living in fuel poverty. This is approximately 33,000 households. This proportion is higher than the South East average (5.7%) but slightly lower than the national average (6.1%). Of all Kent districts, Thanet has the highest number and proportion of households estimated to be living in fuel poverty, (3,654 Thanet households, which is equivalent to 6.6% of all Thanet households). Dover (6.5%), Swale (6.3%) and Shepway (6.2%) also have a higher estimated proportion of households in fuel poverty compared to the national average.

Average annual number of excess winter deaths for all causes for each district in Kent between August 2002 and July 2010



Source: Kent and Medway Public Health Observatory

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The people most likely to die or become ill during the cold weather are those least able to afford to heat their homes. For every one degree Celsius that the outdoor temperature falls below the winter average, there are an 8,000 extra winter deaths in England. This would equate to an estimated 240 deaths across Kent. Living in a cold home can lead to or worsen a large number of health problems including heart disease, stroke, respiratory illness, falls, asthma and mental health problems

Local Profile

Setting Local Priorities: addressing inequalities within Districts

Number of Households living in temporary accommodation 2009-10	
Ashford	99
Canterbury	110
Dartford	61
Dover	49
Gravesham	16
Maidstone	38
Sevenoaks	15
Shepway	76
Swale	73
Thanet	18
Tonbridge & Malling	19
Tunbridge Wells	26

Source: KCT Facts and Figures

The Aspirations

Planners and Commissioners should

i) Use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.

ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively

iii) Assess impact on health inequalities by applying the Impact assessment tool

Action	What Good will look like in 2015	Targets and achievements
5.1 Reduce homelessness and its negative impact for those living in temporary accommodation		
5.1.1 Enable and support a young person aged 16/17 at risk of homelessness to remain within or return to a family network wherever possible and appropriate	• Joint Policy & Planning Board to monitor and review Dartford pilot on joint preventative services between housing and Families & Social Care children's department re homeless 16/17 year olds and roll out across Kent • Fewer young people becoming looked after at age 16/17 • Reduced dependency on the state at age 19 • Strengthen positive relationships within family and social networks	Reduction in numbers living in temporary accommodation with an ambition of 1% pa reduction for those aged 16/17 Outcomes of Child in Need (CIN) assessment by SCS to LA Housing Departments within 10 working days. Number of homeless 16/17 year olds found to be CIN. Length of time support administered by SCS to CIN (refers to the 16/17 year old Homeless Protocol).
5.1.2 Continuation of the Youth Homelessness Education Programme	Currently being delivered by Porchlight and funded by Kent Local Authorities the Youth Education Programme aimed at preventing young people from becoming homeless continues to be rolled out in schools across the county, highlighting the reality of homelessness, signposting to support agencies, developing young people's financial awareness and working to change negative attitudes.	Ambition of 1% pa reduction in numbers of those aged 16-17 living in temporary accommodation

5.1.3 Kent Housing Group and Public Health team will promote HI agenda with Housing Providers	Recognising the influence housing has on health outcomes and inequalities seek to maintain relationship with Kent Housing Group and to influence strategy and planning to address health inequalities	
5.2 Develop our communities to be healthy places		
5.2.1 Rollout initiatives such as House and ACTIV Mobs that help to develop community capacity and sustain positive community outlook.	Relatively small scale interventions designed in partnership with local residents, forming part of wider good quality and sustained neighbourhood working, (family poverty Report recommendation)	House and House on the Move available to young people in town centres
5.2.2 Continue to support affordable ways for people to travel in the community	• Increasing active travel across the social gradient and ensure health inequalities are being addressed by this initiative by • Analysis of postcodes data for purchasing the Kent Freedom Pass and in the future concessionary bus passes. • Evaluation and outcomes of Cycle Instruction and Walking Schemes targeted to schools in deprived areas, including bike loan/and or repair	Take up of Freedom passes, concessionary bus passes.
5.2.3 Develop public rights of way, parks, green spaces and places to play	Improving access and quality of public rights of way, open and green spaces available across the social gradient. Through the Explore Kent website people are signposted to accessible places to go and free events such as guided walking so everyone can get involved	Utilisation of Green space for exercise/health reasons
5.2.4 Reduce the impact of poor housing on health be it physical or mental well being'	• To reduce the numbers of category 1 hazards for falls related hazards, crowding and space, damp and mould, and carbon monoxide HHSRS hazards in the home. • To support a referral system to the local housing authority for raising poor housing concerns.	Reduce number of homes with serious health and safety hazards
5.2.5 Reduce air pollution	Working in partnership to put in place interventions to reduce air pollution that will have co-benefits on health, climate change and the economy.	Air quality action plans in place
5.3 Develop our communities to be safe places		
5.3.1 Working with Fire	Increase the number of above and well above average risk home safety	Reduction in accidental

Service to target most vulnerable households to reduce risk of fire	visit referrals from partner agencies Increase No. of sprinkler installations in vulnerable homes	fires in dwellings
5.3.2 Reduce demand and supply of cheap and illicit tobacco in our communities	Reduction in demand of cheap and illicit tobacco through increased public awareness and community-led initiatives. Reduction in the supply of cheap and illicit tobacco through i) increased intelligence sharing with Trading Standards, HM Revenues and Customs, UK Boarder Agency and the Police / Regional Intelligence Unit; and ii) increased capacity of partners to identify and address illicit tobacco in the community	1% Reduction in the health inequalities gap in Smoking Prevalence rate per annum
5.3.3 Reduce number of children and young people injured on the highway	Walking and cycling initiatives, including walking and cycling to school projects and campaigns Continuing programme of targeted Road Safety projects that have been reviewed and evaluated as effective-e.g. Small Steps – pedestrian training Cycle Instruction B-Viz – campaign to improve visibility especially in winter months Schools continue to produce and promote travel plans	Reduction in road accidents to children
5.4 Reduce Fuel Poverty by supporting development of warm homes		
5.4.1 Update, reissue and promote strategic tools that support the build of warm homes- Kent Health and Affordable Warmth Strategy and the Kent Design Guide	Better/improved joint working between housing and health partners to ensure that homes are warm and safe leading to prevention of falls/COPD/Heart problems, good mental health	Reduction in Excess winter deaths Proportion in fuel poverty
5.4.2 Local housing authorities will continue to ensure housing is decent and not subject to excess cold.	• Reduce Category 1 hazards for excess cold (as assessed using the Housing Health and Safety Rating System) • Incorporate energy efficiency into the referral system of key agencies to increase vulnerable residents' access to available grant/discount schemes.	

6. Strengthen the role and impact of ill health prevention

Many of the key health behaviours significant to the development of chronic disease follow the social gradient: smoking, obesity, lack of physical activity, unhealthy nutrition.
(Marmot Review 2010)

Life-Course 6: Key Priority for Making a Difference in Kent
Reduce the rate of deaths attributable to smoking in all persons

Objective 6: Strengthen the role and impact of ill health prevention

Delivery through- NHS Future Forum; Health Checks; QIPP; Live it Well; No Health Without Mental Health; Tobacco Control Plan; Healthy Weight Strategy; Kent Sport Framework; Alcohol Plan

Priorities	6.1 Improve access to screening	**6.2 reduce the gap in health inequalities across the social gradient**	6.3 Mental Health	6.4 Grow partnerships and find new ways to target and deliver services	6.5 Make every contact count
Actions	6.1.1 Increase coverage of national screening programmes	6.2.1 Improve access to services and target promotion of healthy diet and exercise to reduce obesity	6.3.1 Promote Improving Access to Psychological Therapies programme (IAPT) to deprived areas	6.4.1 Develop healthy settings: healthy living centres, healthy living pharmacies etc	6.5.1 Work with all providers including Acute Trusts, Mental Health Trusts, CCG, GPs, social care etc. to develop plans to give every frontline employee the knowledge and skills they need to support people in making healthier choices.
	6.1.2 Work with District Councils to promote screening uptake to Routine /Manual Workers	6.2.2 Increase equity of access to treatment services for alcohol and drug misuse	6.3.2 Support and promote the 5 ways to wellbeing	6.4.2 Use existing opportunities presented by Gateways, schools, libraries, hospitals, district council offices, leisure centres, job centres etc to promote ill health prevention	
	6.1.3 Increase Health Check programme among those in most deprived areas to ensure early screening and diagnosis	6.2.3 Reduce smoking prevalence with a focus on socio economic groups most likely to smoke **– Key Priority for Kent**	6.3.3 Deliver the mental health impact assessment tool in key locations	6.4.3 Continue to research and gain understanding of health inequalities within our communities and how best to support them to help target scarce resources	6.5.2 Using QOF data identify population level take up of preventative treatments and plan to extend coverage
			6.3.4 Ensure deprived communities also receive mental health awareness via healthy living centres		

See also Sexual Health and falls in section 2

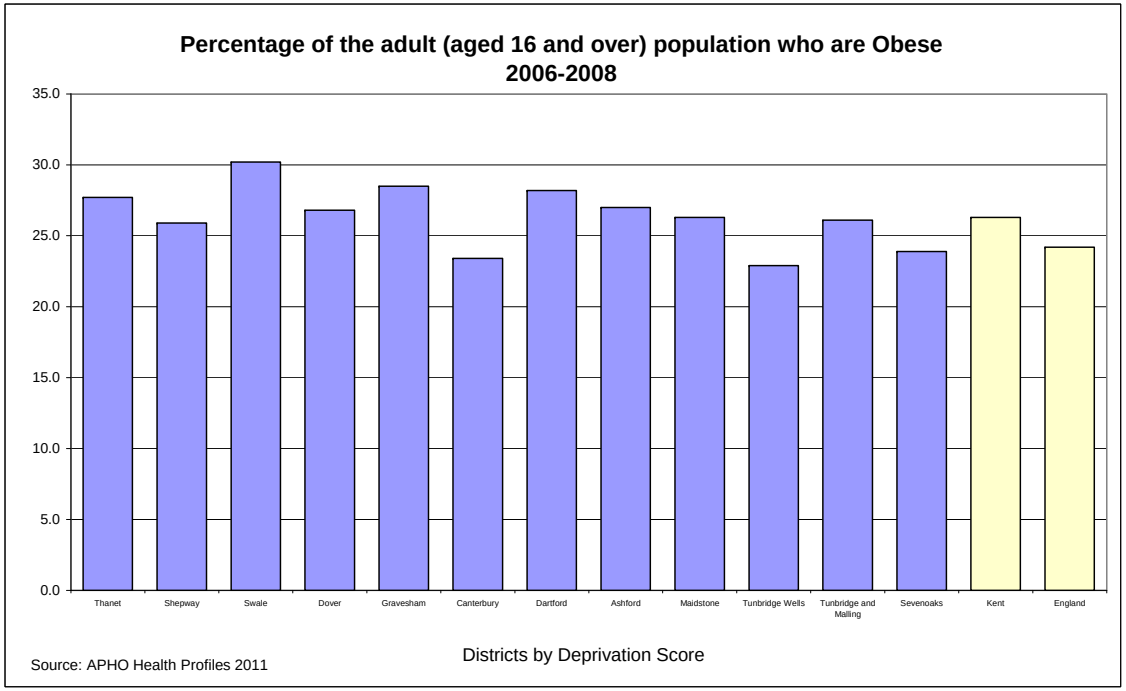
Objective 6: Strengthen Ill Health Prevention

Priority 6.1 Improve access to screening

The aim of national screening is to reduce the amount of disease in a population, or to detect disease at an early stage to improve patient outcome. The most deprived and ethnic minority groups are less likely to take up screening.
The incidence and prevalence of vascular diseases reflect health inequalities in the UK and the widening gaps in life expectancy between the most and the least disadvantaged in society. Gaps in life expectancy across west Kent, for example, can be as high as 14 years. There are also inequalities in the uptake of cervical cancer screening through low uptake amongst younger women with only 69% coverage across Kent for those aged 25-29.

Priority 6.2 Focus public health interventions to reduce the gap in health inequalities across the social gradient

Obesity: Adult obesity is far more prevalent in socially disadvantaged groups. It is estimated that approximately 28% of the Kent population is obese (354,022).



Cost burden of obesity to SEC PCTs 2006

PCT	NHS Cost of principle diseases related to obesity (millions)
Eastern and Coastal Kent	279.2
West Kent	221.4

Smoking: Smoking prevalence in Kent is 24.9%; however there is a significant amount of variation across Kent and it is a major reason for our health inequalities. Routine and manual smokers represent the single biggest group of smokers –half of all smokers belong to the routine and manual group
Of the 11,250 deaths of Kent residents aged 35 and over in 2008, approximately 2,250 (20%) can be attributed to smoking. Approximately 10,300 hospital admissions of Kent residents aged 35 and over in 2008 can be attributed to smoking (5% of the total 205,932 admissions). The majority of these are due to lung cancer, chronic airway obstruction and ischaemic (coronary) heart disease.

Alcohol Misuse: The impact of alcohol misuse is widespread; it encompasses alcohol related illness and injuries as well as significant social impacts including crime and violence, teenage pregnancy, loss of workplace productivity and homelessness. Health inequalities are clearly evident as a result of alcohol-related harm; national data indicates that alcohol-related death rates are about 45% higher in areas of high deprivation. It is estimated that 259,103 adults in Kent are drinking at 'increasing risk' levels or 'high risk' levels. In 2009-10 the equivalent of 24,682 people in Kent were admitted to hospital for alcohol related harm, costing over £45 million.

Substance Misuse: There are strong links between levels of deprivation, prevalence of problem drug use, drug related hospital admissions and mortality. Estimates indicate that there are between 3640 and 7591 problem drug users in Kent and that a further 2500 problem drug users are not engaged with services. Hospital admissions continue on an upward trend.

Drug-specific admissions (primary diagnosis) per 100,000	2006/7	2007/8	2008/9	2009/10	2010/11
All Kent	14.21	16.72	10.14	15.81	16.77
East Kent	14.84	17.75	11.36	16.67	18.20
West Kent	12.86	15.26	9.36	14.53	15.79

Priority 6.3 Mental Health

'Mental Health, Resilience and Health Inequalities' by Dr Freidli lays down the basic premise and research for what became the government's strategy for mental health in 2011, "No Health without Mental Health". Endorsed by the WHO, Faculty of Public Health and Child Poverty Action Group it describes what we all know in our bones, that without our sense of well being, without our ability to be resilient to life's slings and arrows *and* without understanding that chronic stress literally gets under our skin in the form of illness – we will become sick.
Sadly, although money can't buy us happiness- it does by and large buy us security and ability to mitigate against some unexpected life events e.g. unemployment. Communities that exist in areas of greater deprivation need more then ever, the tools (both collective and individual) to cope with stresses and life events. It is fine to ask people to give up smoking, eat healthily, drink less and go to the gym more, but some of the reasons that people in more deprived areas engage in behaviours that on the surface are worse for health, are because they are struggling to find ways to cope with stress.

Chronic stress impacts on long term relationships and can even lead to violence, isolation and neglect. This is why mental well being is a core issue in tackling health inequalities. What is the antidote from a health perspective? Well obviously creating more jobs and being able to have skills to gain employment are central to this, and these are a key part of the wider Kent Strategy to tackle disadvantage. But from a well being and health perspective there are things we can do too: building social support and networks are essential for building communities (echoed in

the Big Society), having good access to psychological support and places to go where you can find a shoulder to cry on, just by recognising ones emotional health and finding ways of coping can be the difference between suicide and hope. This links to the new health service mantra "make every contact count". Everyone can do their bit.
In addition: people who have mental health problems, who are depressed or who have a more serious condition like schizophrenia face discrimination, stigma and poorer health outcomes. People with a mental illness can suffer name calling, poorer access to routine services and on average live 15 years less life then other people.
So in summary health inequalities and mental health are linked in two ways, firstly if you live in a deprived area you are (by and large) likely to experience more life events and stresses which can be hard to cope with and which can make you ill faster and secondly poorer areas are more likely to have higher crime and violence – which in turn can feel stressful and make us feel depressed. To echo both Dr Freidli's report and the sentiment in the Big Society "*"no one survives without community and no community thrives without the individual". http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf*

Priority 6.4 Grow partnerships and find new ways to deliver services in places where people go

Reducing barriers so that everyone, but especially those dealing with stigmatization or discrimination is able to access health services as locally as possible. Bringing services closer to patients and communities may substantially improve uptake, presentation and utilisation. Patient pathways should be designed with this in mind.

Priority 6.5 Make every contact count

The NHS Future Forum recommended in January 2012 that

Every healthcare professional should "make every contact count": use every contact with an individual to maintain or improve their mental and physical health and wellbeing where possible, whatever their specialty or the purpose of the contact.
The NHS's role in the public's health: A report from the NHS Future Forum Jan 2012

In Kent we want to support this approach and ensure it is extended through our health and social care workforce as we move towards integrated services.

Local Profile

Setting Local Priorities: addressing inequalities within Districts

Smoking attributable mortality					Projected				**Actual**	
					Year 1	Year 2	Year 3	Year 4	**Year 1**	Performance against target
	Year	**Baseline**	**Target improvement**	**Rate in 2015**	2008-10	2009-11	2010-12	2011-2013	**2008-10**	
Ashford	2007-2009	183.9	1% year on year reduction	176.6	182.1	180.2	178.4	176.6	**170.7**	**-6.4%**
Canterbury	2007-2009	198.4	1% year on year reduction	190.6	196.4	194.5	192.5	190.6	**192.6**	**-2.0%**
Dartford	2007-2009	220.9	1% year on year reduction	212.2	218.7	216.5	214.3	212.2	**219.9**	**0.6%**
Dover	2007-2009	225.7	1% year on year reduction	216.8	223.4	221.2	219.0	216.8	**208.3**	**-7.0%**
Gravesham	2007-2009	211.3	1% year on year reduction	203.0	209.2	207.1	205.0	203.0	**200.2**	**-4.4%**
Maidstone	2007-2009	195.7	1% year on year reduction	188.0	193.7	191.8	189.9	188.0	**198.5**	**2.5%**
Sevenoaks	2007-2009	172.2	1% year on year reduction	165.4	170.5	168.8	167.1	165.4	**158.6**	**-7.2%**
Shepway	2007-2009	219.6	1% year on year reduction	210.9	217.4	215.2	213.1	210.9	**205.1**	**-5.8%**
Swale	2007-2009	227.8	1% year on year reduction	218.8	225.5	223.3	221.0	218.8	**230.4**	**2.2%**
Thanet	2007-2009	277.0	1% year on year reduction	266.1	274.2	271.5	268.7	266.1	**245**	**-11.0%**
Tonbridge and Malling	2007-2009	180.9	1% year on year reduction	173.8	179.1	177.3	175.5	173.8	**176.1**	**-1.7%**
Tunbridge Wells	2007-2009	168.7	1% year on year reduction	162.0	167.0	165.3	163.7	162.0	**163.9**	**-1.9%**
England	2007-2009	216.0			213.8	211.7	209.6	207.5	N/A	

Source: Baseline and projected Local Tobacco Profiles, Jan 2012; Actual: KMPHO calculated

The Aspirations

Planners and Commissioners should

i) use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.

ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively

iii) Assess impact on health inequalities by applying the Impact assessment tool

Action	What Good Will Look Like in 2015	Targets and achievements
6.1 Improve access to screening		
6.1.1 Increase coverage of national screening programmes	There will be increasing take up from groups who traditionally do not attend screening in addition to greater uptake overall. Health Equity Audits focusing on patterns of uptake and coverage will be a basis for action.	Kent's screening programmes will be well regarded with relatively high coverage levels.
6.1.2 Work with District Councils to promote screening uptake to Routine/Manual Workers		
6.1.3 Increase Health Check programme among those in most deprived areas to ensure early screening and diagnosis	NHS Health Check programme having both a universal and a more targeted delivery via a plurality of providers, including those from non-clinical, non-NHS sites, so that those with the greatest health needs are effectively reached by the programme	Health checks' are to be provided to people between 40 and 74 years across Kent. With full roll out 880,211 checks are to be delivered across Kent on an annual basis from 2013
6.2 Focus public health lifestyle interventions to reduce the gap in health inequalities across the social gradient		
6.2.1 Improve access to lifestyle self support and dedicated services	The Health Trainer service had been developed to target those in areas of high deprivation. Pathways from services into lifestyle behaviour programmes are clear and easily accessible so that people at risk following a health check or coping with chronic conditions where diet and physical activity would make a difference have improved outcomes. Services have been reviewed, are fit for purpose and provide quality interventions.	Slow the increase in obesity in adults by 1% per annum in the health inequalities gap Number of adults classified as overweight or obese

6.2.2 Increase equity of access to treatment services for alcohol and drug misuse	• Industrialising opportunistic Identification and Brief Advice (IBA) for those at risk through alcohol misuse as part of Healthy Lifestyles services through local authority commissioning for prevention. • Increased awareness and support to veterans regarding substance and alcohol misuse and mental health • For problem drug users structured counselling, intensive family based interventions, practical group work activities and better links with mental health services will be used to develop relevant social skills that increase service users capacity to sustain long term improvements in terms of substance use and their health and social functioning. Recovery focused intensive keyworking will also provide a specific focus throughout the treatment journey (JSNA)	1% reduction in mortality from liver disease. 1% reduction in drug misuse. 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
6.2.3 Reduce smoking prevalence with a focus on socio economic groups most likely to smoke (see also objective 3)	Assessment of risk factors for early identification of people with COPD and Lung cancer has led to more effective targeting of services leading to evidence of smoking prevalence reduced in cohorts: - Routine/Manual workers in Kent - Prison population in Kent - Pregnant women - Families who smoke in areas of deprivation Stop smoking services should aim to treat at least 5% of the local smoking population each year. In Kent, this equates to at least 14,000 smokers	1% reduction per annum in the health inequalities gap of smoking prevalence rates 1% reduction in the health inequalities gap In the rate of deaths attributable to smoking in all persons Mortality from lung cancer directly ASR for persons <75*+slope index
6.3 Mental Health		
There is an embedded approach across partners to improve mental well-being that also addresses the broader determinants of mental health and can measure the impact of changes to well being. There can be no health without mental health and those experiencing stigma or discrimination will be supported.		
6.3.1 Promote Improving Access to Psychological Therapies programme (IAPT) to meet demand	Training for staff and access to new or improved services to help children, young people and adults with depression or anxiety within their own communities.	
6.3.2 Support and promote the 5 ways to wellbeing		http://www.liveitwell.org.uk/
6.3.3 Deliver the mental health impact assessment tool in key locations	Mental Wellbeing Impact Assessment (MWIA) enables local service commissioners and community organisations to assess and measure the impact of their interventions on their	

	population's mental health and wellbeing. It will provide an effective approach to creating policy and services that have the best possible impact on mental well-being	
6.3.4 Ensure deprived communities also receive mental health awareness via healthy living centres		
6.4 Grow partnerships and find new ways to target and deliver services in places where people go (Asset based community development)		
6.4.1 Develop healthy settings: healthy living centres, healthy living pharmacies etc.	Partner organisations including the 3rd sector come together to tackle broad health issues within a community. Such hubs promote good health and well being by encouraging healthy lifestyle choices and provide tailored support, advice and guidance to tackle local issues, such as debt, family relationships etc	
6.4.2 Use existing opportunities presented by Gateways, schools, libraries, hospitals, district council offices, the 3rd Sector, leisure centres, job centres etc to promote ill health prevention	A range of services and information are being delivered and signposted through a range of providers in places where the public consider key touch-points of their lives. This brings partner agencies together and enable people to have a comfortable experience and positive interaction with services	
6.4.3 Continue to research and gain understanding of our communities and how best to support them to help target scarce resources	More accurate understanding of prevalence by district has influenced commissioning of targeted services leading a reduction in the social gradient (the gap has narrowed between the health of the richest and the poorest)	
6.5 Make every contact count		
6.5.1 Work with all providers including Acute Trusts, mental health trusts, CCG, GPs, social care etc. to develop plans to give every frontline employee the knowledge and skills they need to support people in making healthier choices	The Kent health and social care workforce is competent to provide advice and support about staying healthy at key life stages or times when people are more likely to be open to change and in touch with services (such as pregnancy, starting or leaving school and entering or leaving the workforce, caring for a sick relative or experiencing ill health)	Workforce plans and training in place
6.5.2 Using QOF data identify population level take up of preventative treatments and plan to extend coverage	QOF data is interrogated and used to support CCGs in identifying gaps in take-up of preventative treatment leading to targeting and intervention with individuals and communities at high risk.	Mortality from causes considered preventable

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