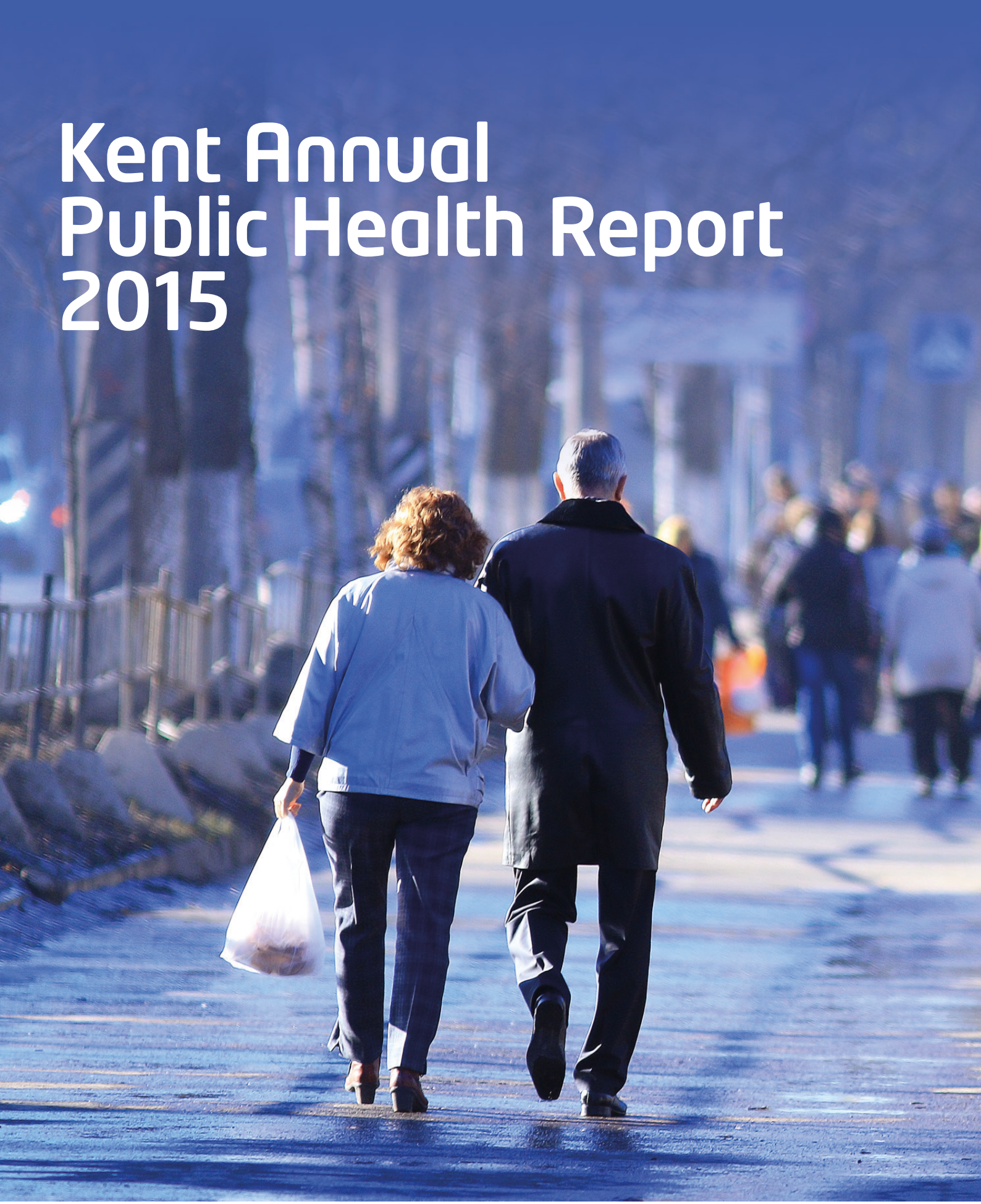
Kent Annual Public Health Report 2015



Health Inequalities

Kent County Council
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Foreword

Health Inequalities are the differences in health outcomes within and between communities. We measure health inequalities overall through health statistics such as life expectancy or all-age, all-cause mortality rates or more specifically for specific disease mortality rates such as cancers, cardiovascular or respiratory disease rates. We will also segment populations based on social, environment and health characteristics, for example deprivation, to provide greater understanding of the true nature of health inequalities we see in Kent.

In 2012 Kent County Council agreed to the 'Mind The Gap' action plan which signalled a Kent wide approach to reduce the 'gap' in health outcomes across the county. The action plan followed the key objectives set out in Sir Michael Marmot's 'Fair Society, Healthy Lives' report published in 2010 which set out to propose the most effective evidence-based strategies for reducing health inequalities in England. Those objectives include:

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

Whilst these objectives remain absolutely important, I'm also aware that the health inequality gap has not closed. I have no doubt that action has and is being taken, however that action is not consistent across the Kent population, the risk being that local work serves to increase health inequalities between communities rather than to reduce them. My annual report of 2015 reflects on where we have got to in Kent, and points to what we need to do in the future if we are going to have any success in narrowing the gap.

Andrew Scott-Clark
Director of Public Health, Kent County Council

Acknowledgements

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1 Executive Summary

- **Health inequalities refer to the avoidable differences in health status between individuals depending on their life circumstances. Our health is shaped by the conditions in which we are born, grow, live, work and age.**

- **Reducing health inequalities is a major policy objective both nationally and locally. It is now a statutory responsibility of Local Authorities and the NHS to take action to reduce health inequalities.**

- **Kent's 'Mind The Gap' health inequalities strategy for 2012-15 was successful in raising awareness about the wider determinants of health, and the role of actors both within and external to the health sector in reducing the impact of health inequalities.**

- **This annual report sets out the progress around key indicators of health inequalities and features examples of the initiatives that are having an impact.**

- **Our analysis demonstrates that the most deprived decile populations have disproportionately worse health outcomes, and we can map the geographical locations of these populations in Kent**

- **Moving forward, our health inequalities action plan will be to better work with partners across local government, the health and social care sector, and local communities, to improve health and wellbeing in deprived areas.**

2 Introduction

2.1 What are Health Inequalities?

Health inequalities refer to the avoidable differences in health status between individuals depending on their life circumstances. It is now widely recognised that our health is shaped by the conditions in which we are born, grow, live, work and age [Figure 1]. Whilst Kent scores above the England average on a range of health indicators, this hides significant disparities in health outcomes which exist within and between Kent's communities. Depending on where you are born in Kent, you could statistically be expected to live to the age of 73 years (Margate Central in Thanet) or 90 years (Kingsgate, also in Thanet).

Across England, premature deaths cumulatively represent up to 2.5 million potential years of life lost each year. There are also strong economic arguments for addressing these inequalities. Given the UK's aging population, rising pension age, and cost pressures on the health and social care system, it is vital to ensure that health gradients are reduced and people enjoy more years of life free of disease and disability, ensuring greater economic productivity, self-sufficiency and independence into old age.

Tackling inequalities is a challenge, but there are reasons to be optimistic: informatics and data linkage can provide deep insights into populations like never before; innovative new models of integrated care; smarter commissioning and passionate clinical leaders; exciting and inspiring community-led initiatives. There is now wide recognition right across local government, the NHS, and communities, of the need to address health inequalities in Kent.

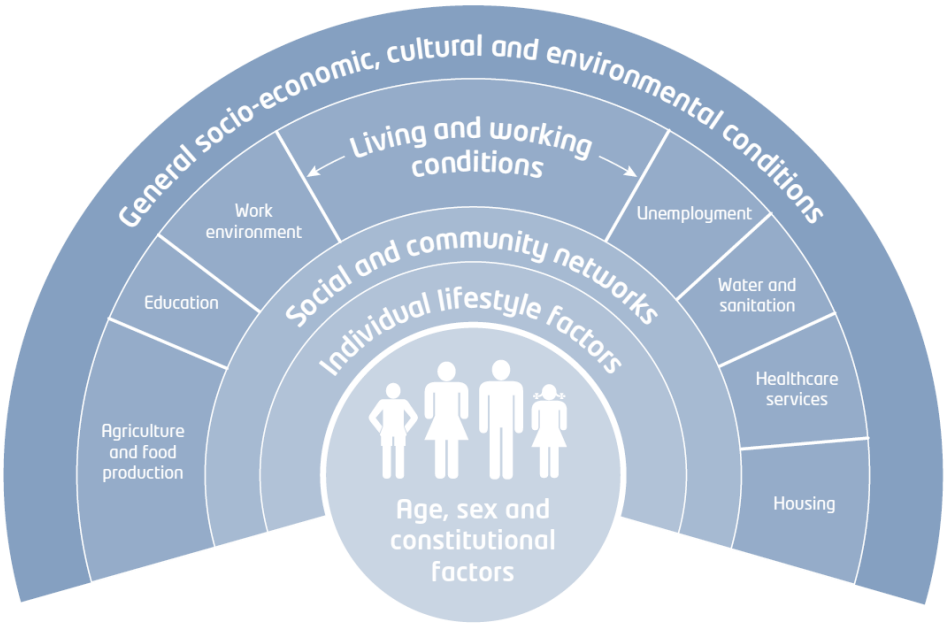


Figure 1 **Dahlgren and Whitehead's Social Model of Health (1991)**

2.2 The Marmot Review

The latest national strategy to tackling health inequalities, "Fair Society, Healthy Lives", was released in 2010 and is also known as the Marmot Review. Summarising the wealth of new research into health inequalities that had occurred since the previous national strategies into health inequalities; the Acheson Report (1998) and the Black Report (1980), the Marmot Review particularly stressed the action that would be required on the social determinants of health, such as education and employment. It also recognised that inequalities accumulates as we age, beginning even before birth. The six main policy objectives (below) take a 'life course approach' [Figure 2], from the early years through to aging. Kent's performance compared to England is summarised in the table in Appendix 1, showing that Kent is doing better than England on most indicators. Despite this, we know that inequalities continue to exist within and between Kent's communities.

A) Give every child the best start in life

B) Enable all children, young people and adults to maximise their capabilities and have control over their lives

C) Create fair employment and good work for all

D) Ensure a healthy standard of living for all

E) Create and develop healthy and sustainable places and communities

F) Strengthen the role and impact of ill-health prevention

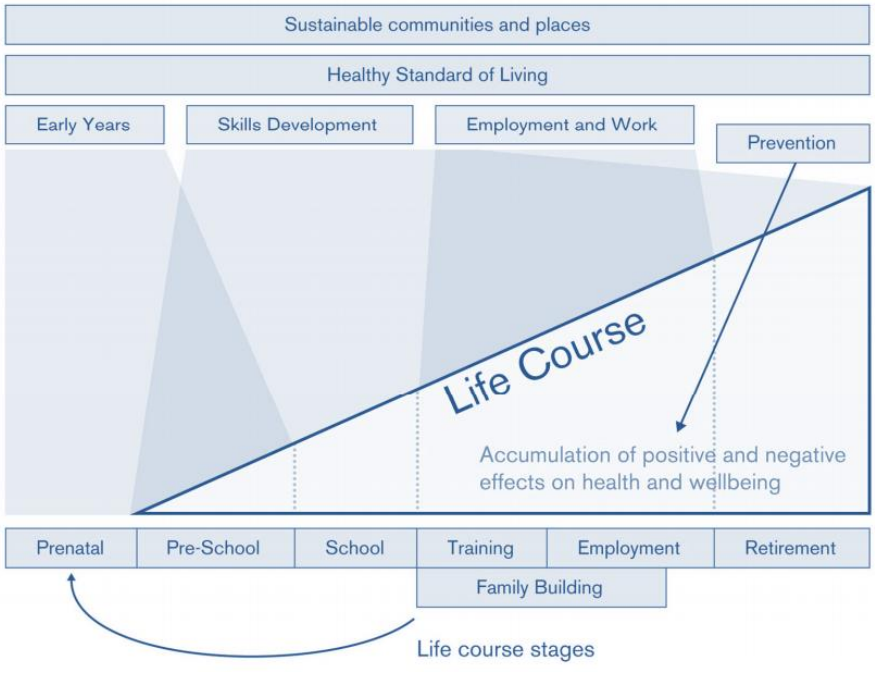


Figure 2 'Life Course' approach from The Marmot Review

2.3 Mind The Gap

In 2012 the 'Mind The Gap' action plan was formulated by Kent County Council to reduce the gap in health outcomes between the least deprived and most deprived communities in Kent. The strategy was an opportunity to produce a unified plan to guide the actions of Kent County Council, district councils, and community partners, in efforts to address the underlying determinants of health. The objectives and priorities for 'Mind The Gap' followed those set out by the Marmot Review.

Since the publication of 'Mind The Gap' responsibility for Public Health in England has shifted from the NHS to local authorities, where the levers exist and partnerships can be made to better influence the wider determinants of health. 'Mind The Gap' succeeded in raising awareness about the impacts other sectors can have on health in the county. Following on from the action plan, a number of Kent's district councils produced their own health inequalities strategies, based on its recommendations. However, systematic action has been variable, limiting the overall impact to reduce inequality.

Now, three years later, we are able to reassess the latest data and renew our efforts to tackling health inequalities. Whilst Kent performs better than the England average on a number of indicators [Appendix 1] there remains significant disparity between the health outcomes of richest and the poorest. A better measure of progress is to see if our efforts are reducing health inequalities across the county.

3 Health Inequalities in Kent Today

The level of deprivation for a particular geographic area can be measured by the 'Indices of Multiple Deprivation', a national scoring methodology which includes multiple factors: income, employment, education, skills, health, crime, housing and the environment.

The map below shows how deprivation varies across Kent, with darker areas being wards with higher levels of deprivation [Figure 3]. This shows that deprivation in Kent tends to be higher in the eastern parts of the county than the western parts. Deprivation also tends to be higher in coastal towns and urban centres. There is also rural deprivation in some areas, related to less access to services.

For most health issues analysed (e.g. smoking prevalence, obesity rates, mortality rates and life expectancy), what we find is that the areas of higher deprivation have worse health outcomes. This is not a surprising finding and nor is it unique to Kent. It has long been known in the field of public health that poorer populations tend to suffer from poorer health.

Are health inequalities reducing in Kent? One way of assessing this is looking at how mortality rates have changed over time for the most affluent and most deprived populations.

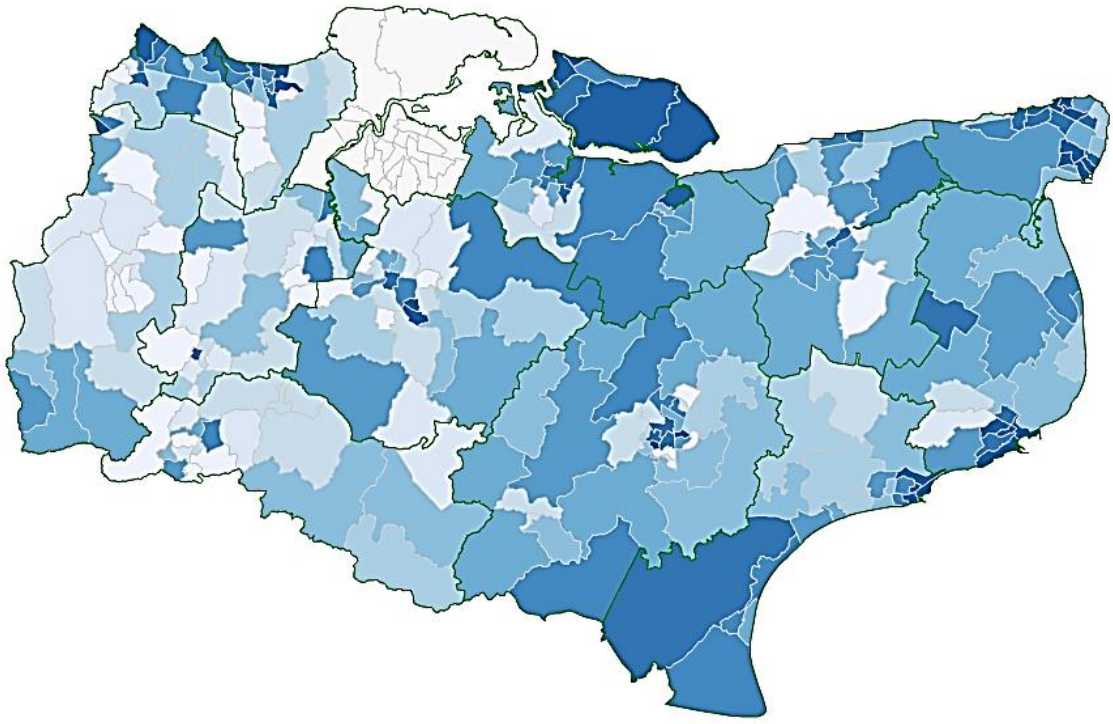


Figure 3 **Indices of Multiple Deprivation (IMD) 2015, ward map of Kent**

Figure 4 shows the change in mortality rates in Kent over the last decade, with the top line showing the most deprived population and the bottom line showing the least deprived population. Mortality rates are decreasing across all groups (all the lines are decreasing). This is a significant success for our population; we are all living longer in Kent, across all groups in society.

But *the gap* between the top line and bottom line remains unchanged. So the difference between the mortality rates of the most and least deprived is not changing. In order to close 'the gap', we need to speed up the rate of reduction in mortality rates in the most deprived decile.

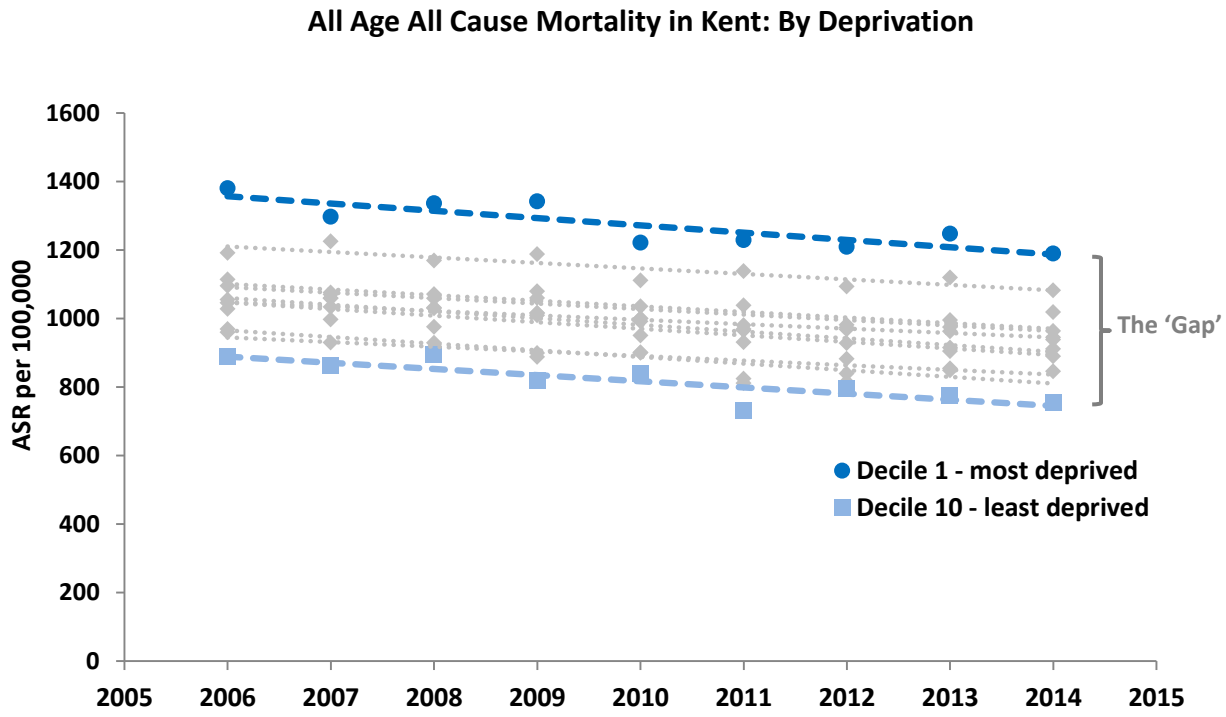


Figure 4 **Changes in Mortality Rates in Kent by deprivation decile (2006-2014)**

Inequality in Mortality Rates

The gap in mortality rates between the most and least deprived remains unchanged in Kent over the last decade

In the following chapters in this report, we will look at each of the six Marmot policy objectives and consider the progress that has been made in Kent, with examples of good practice.

A) Give every child the best start in life

A child's early years lay down the foundation for the rest of their life, and the first three years are the most critical. This is a crucial period of physical, intellectual and emotional development.

Inequalities are introduced before birth, as the health of a child is greatly affected by the health of their mother during pregnancy. Maternal stress, diet, smoking, drug and alcohol use all influence a baby's development in the womb. **Low birth weight** and premature delivery are both associated with social disadvantage and lead to poorer health outcomes.

The percentage of term babies with a low birth weight in Kent has been stable at about 2.3%. The rate of **still births** is about 4.6 per 1000 total births, and the **infant mortality** rates have decreased in recent years to 2.9 deaths per 1000 births live births. One area that has been highlighted in Kent is the number of sudden unexpected deaths in infants that are related to co-sleeping, and a campaign is being formulated to raise awareness.

Smoking in pregnancy is an adverse health behaviour that is known to impact on foetal development in the womb. Smoking status at time of delivery has been reducing in Kent over the last few years, but the county rate of 12.6% is above the national average of 11.4%. The figure varies within Kent; in Swale as many as one in five pregnant women continue to smoke.

Breastfeeding contributes significantly to the long term health of both infants and mothers, and increases maternal bonding. The breastfeeding initiation rate in Kent has decreased over the last few years and is now 71.3%, which is below the national average (74.3%).

Babyclear Programme

Babyclear is an intervention to support pregnant women to stop smoking and have healthier babies. The programme is delivered by midwives, who perform a carbon monoxide test in all pregnant women, and refer those who smoke directly into stop smoking services. The training has received good feedback and is being delivered to all midwives in Kent.

Breastfeeding Group

Swale has a particularly low rate of breastfeeding initiation. The CCG has therefore set up a multi-agency project group over the last 2 years. One example of their work is collaboration with the Best Beginnings charity and their 'From Bump to Breastfeeding' resource. The group is currently developing a formal breastfeeding pathway for Swale.

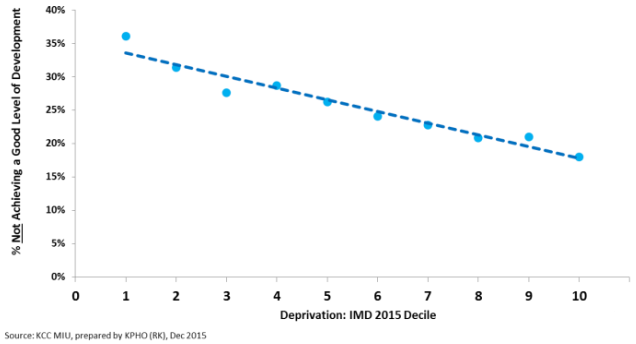


Figure 5 School readiness by deprivation, Kent 2013

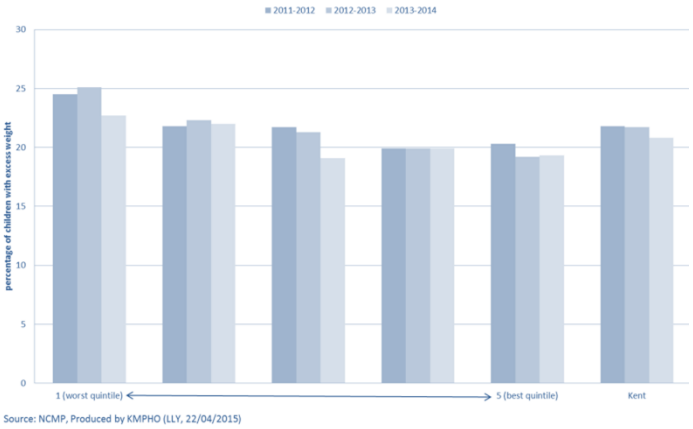


Figure 6 YR childhood obesity by deprivation 2011-2014

Teen pregnancy has adverse effects on both mother and child. Babies born to teen mothers are more likely to be born into poverty, do less well at school, and are more likely to become teenage parents themselves. In Kent, the under-18 conception rate has fallen dramatically over the last decade to 22.2 per 1000. However, rates are still higher than this in areas of deprivation.

After birth, the first few years of life are crucial in shaping a person's life chances. The development of early cognitive ability is strongly associated with later educational success, income and better health. Figure 5 shows how **school readiness** (or 'good childhood development') varies by deprivation in Kent, with more deprived deciles having a higher proportion of children who do not achieve a good level of development.

Our experiences in childhood affect behaviours and habits which persist into adulthood. Even at the young age of 5, there is already a social gradient in **childhood obesity** rates in Kent [Figure 6]. There has been a marginal improvement in Reception Year (YR) obesity rates over the last few years. Family Weight Management Programmes, such as 'Go For It' in Maidstone, provide advice and promote behavioural modifications to improve lifestyles.

The Family Nurse Partnership

The Family Nurse Partnership is an intensive, evidence-based preventive home visiting programme to teen mothers in Kent (including their partners) delivered by specially trained nurses from early pregnancy until the child is 2 years old. The aims are to improve maternal health during pregnancy, child health and development, and parents' economic self-sufficiency. Operating in parts of Kent, the service is targeted at districts with the highest teenage pregnancy rates. Family Nurses are highly skilled and successful in engaging young parents, and have a high retention rate. Some of the core elements of the FNP programme are reducing rates of smoking, reducing A&E attendances and hospitalisation, increasing rates of breastfeeding and improving maternal health. The programme also supports young parents in returning to education, training, or employment. Feedback from parents continues to be overwhelmingly positive.

B) Enable all children, young people and adults to maximise their capabilities and have control over their lives

The accumulation of experiences during childhood shapes both the choices they will make as adults as well as their long term health. Schools and families together have important roles in promoting the development of children - physically, socially and emotionally, as well as cognitively. Low educational attainment is closely associated with poorer health outcomes.

Education is impacted not just by schooling, but also by family background, neighbourhoods and peer groups, and is therefore closely associated with deprivation. Figure 7 shows how **GCSE attainment** varies across Kent, with darker areas showing a lower proportion of children achieving 5 GCSEs graded between A* and C. Compared to the Kent average of 58%, only 27% of children receiving free school meals achieve 5 good GCSEs. The **attainment gap** has been recognised as an area for improvement, and is key to reducing inequalities.

It is also important to focus on young adults in the years after compulsory education, which is a key transitional period into adulthood. Young people age 16 to 25 are those most likely to be unemployed or in low-skilled jobs. Kent's *Learning, Employment and Skills Strategy* is showing significant progress, and the number of 16-18 year olds **'Not in Education, Employment or Training'** has continued to fall, to under 5%.

However, childhood development is not just about educational attainment. We should also enable children to develop their personalities, talents, self-esteem and resilience, to allow them to lead flourishing lives. Activities such as sport, music, drama and the arts allow children to develop well-rounded skill sets and such

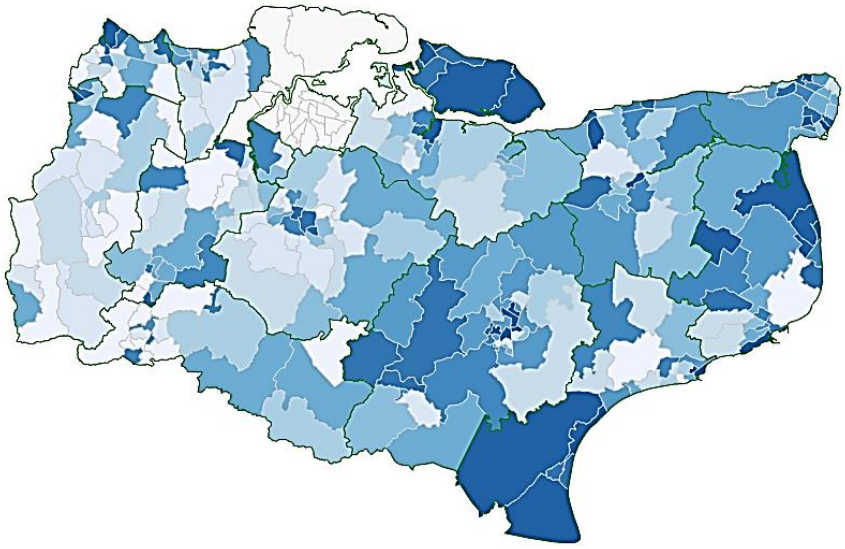


Figure 7 GCSE Attainment, 2013, ward map of Kent

opportunities should be fostered both by schools and local communities. Extra-curricular activities can help to keep children physically active and reduce obesity. **Year 6 obesity** rates, which demonstrate a social gradient, have shown no improvement over the last few years [Figure 8].

Emotional wellbeing and mental health is another important area for children and young adults. Nationally, rates of **mental illness** continue to increase. This is significant as mental wellbeing and resilience underpins other health behaviours and "there is no health without mental health". Rates of mental illness in Kent continue to be strongly associated with areas of deprivation. There are varying levels of need which requires a 'whole system' approach to support children and young people (from early help through to specialist services). An example initiative is the *HeadStart* programme running in Thanet, Canterbury and North West Kent for 10-14 year olds.

A group that have particularly complex and health and social care needs are **asylum seekers and refugees**. Since 2014 there has been a significant increase in the numbers of unaccompanied asylum seeking children (UASC) in Kent, a group with a high prevalence of psychological symptoms.

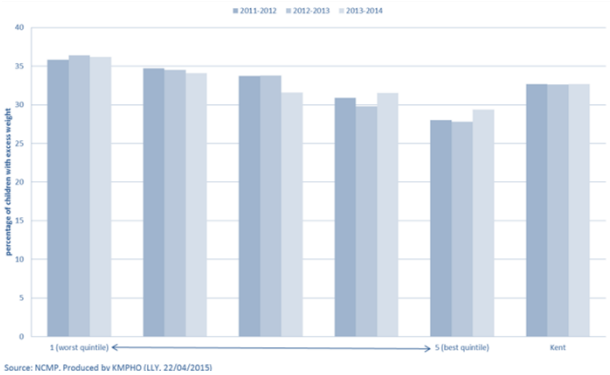


Figure 8 Year 6 obesity rates by deprivation 2011-14

Troubled Families

This programme aims to improve the life chances of Kent's most disadvantaged families. A dedicated worker builds a relationship with the family, assessing needs and coordinating services. The four main aims are to reduce school absence, antisocial behaviour, offending rates and unemployment. Kent achieved its targets for phase 1 of the programme and is expanding to include more families and wider criteria in line with phase 2 of the national programme.

Emotional wellbeing is defined as:

"a positive state of mind and body: feeling safe and able to cope, with a sense of connection with people, communities and the wider environment." **WHO 2004**

C) Create fair employment and good work for all

Patterns of employment both reflect and reinforce the social gradient, and being in good employment is protective of health.

Unemployment leads to financial insecurity, psychosocial stress, anxiety, depression and unhealthy behaviours such as smoking and alcohol consumption. A vicious cycle can be created, as the resulting ill-health and disability can further reduce the likelihood of ever returning to employment.

Rates of **unemployment** are highest among those lacking qualifications, people with disabilities and mental ill health, those with caring responsibilities, lone parents, older workers, and young people. Figure 9 shows the Job Seekers Claimant rate across Kent, which closely correlates with areas of higher deprivation.

In Kent, the unemployment rate has been reducing over the last few years in all districts, as the nation's economic recovery continues [Figure 10]. The unemployment rate overall is 5.0%, less than the England average (6.0%).

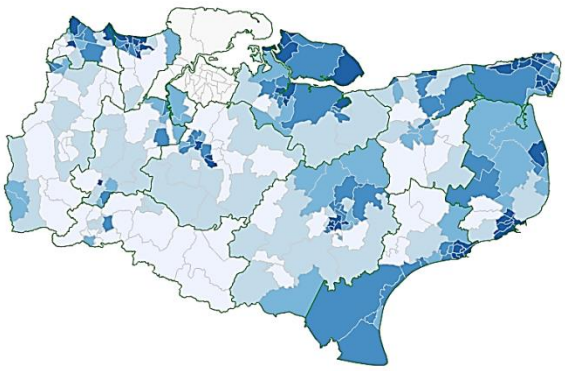
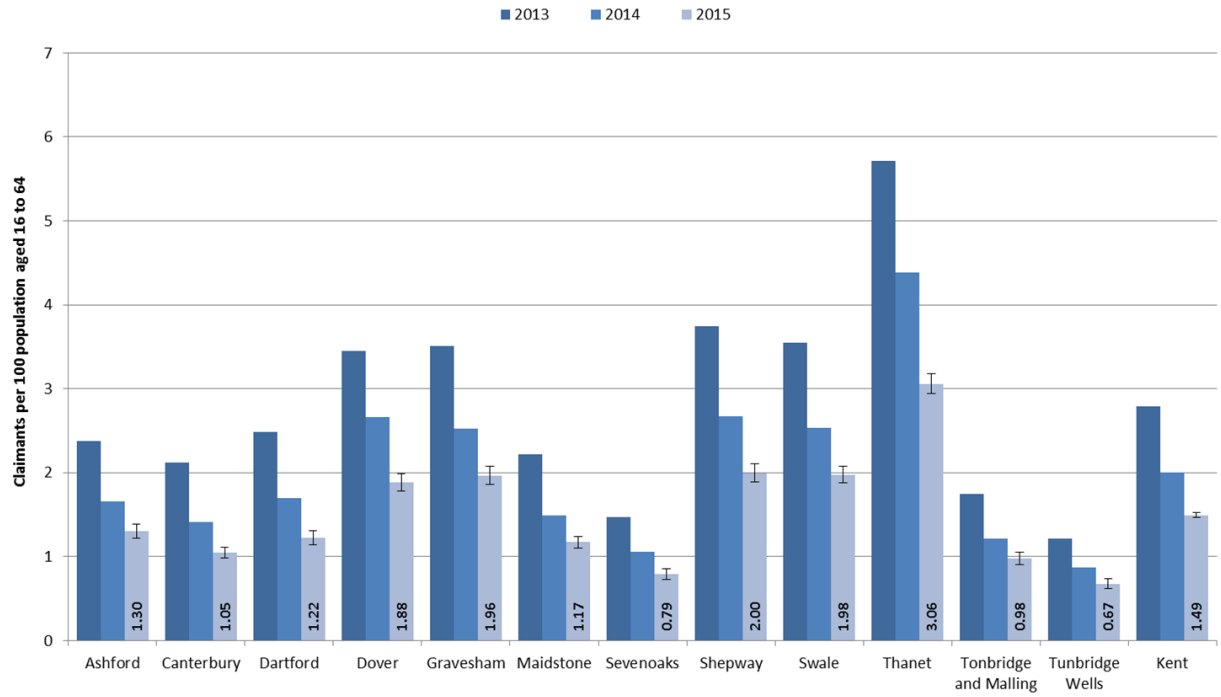


Figure 9 Job seekers claimant rate in Kent, 2015

The **quality of work** is also important. Jobs that are insecure, low-paid and fail to protect employees from stress and physical danger lead to poorer health. Common work-related illnesses include mental health problems and musculoskeletal disorders. The largest industry group in Kent is the professional, scientific and technical industry (17.4%) and the construction industry is the second largest (15.1%). Kent also has a high proportion of small businesses; 76.5% of all Kent's businesses employ 1-4 people.

Businesses and workplaces have a key role to play in supporting good health and reducing health inequalities. Supervisor and peer support, stable rotas, safe conditions, opportunities for training and promotion, and greater autonomy in the workplace are all factors that increase employees' wellbeing. Better **workplace health** can be promoted through healthier food options and opportunities to increase physical activity.



Source: NOMIS, prepared by KPHO (ES), 04/16

Figure 10 Unemployment rates in Kent by district - 2012, 2013, 2014 (percentage of workforce age 16-64 unemployed)

Health at Work

The Kent Healthy Business Awards programme provides business engagement across the system to promote health at work, improve access to preventative services and encourage healthy lifestyle choices across the Public Health agenda. The awards are based on the National Workplace Health and Wellbeing Charter, with 9 main themes:

- leadership
- attendance management
- health and safety requirements
- mental health and well being
- smoking and tobacco
- physical activity
- healthy eating
- alcohol and substance use
- environment

Currently, Kent Healthy Business advisors based within district local authority teams are working with approximately 200 businesses of which at least 85 (32,287 employees) have signed their commitment and are working towards the standards. In 2015, eighteen businesses achieved awards. The golden thread running through the standards is leadership, communication and culture, with a commitment to improve staff health and wellbeing.

The Workplace Challenge is a Kent wide campaign by Kent Sport that gives businesses the chance to win points and prizes in friendly competition by allowing employees to log the amount of physical activity they are doing. For more information, visit http://www.workplacechallenge.org.uk/kent/

D) Ensure a healthy standard of living for all

Income is a key determinant of health. Insufficient income is associated with worse outcomes in long term health and life expectancy. The **median income** in Kent has risen steadily since 2002 by 31.5%, though there remain significant differences between the districts [Figure 11]. In the forthcoming years those on low wages in Kent will be affected by welfare reform and national policy changes to taxation, benefits, and the minimum wage. **Financial debt** can have a significant impact on mental wellbeing, stress and anxiety.

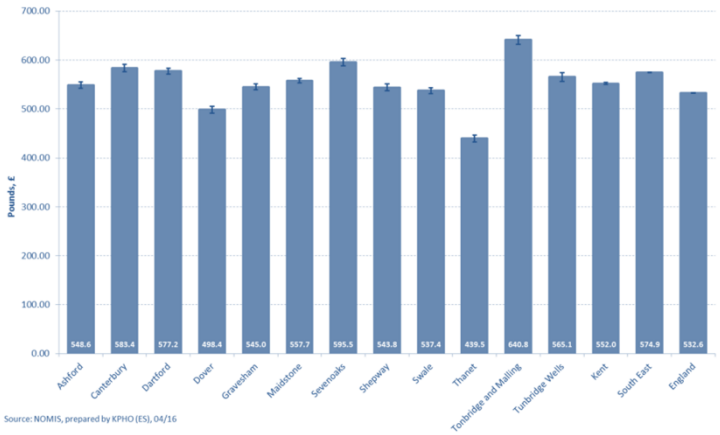


Figure 11 Gross median weekly wage in Kent 2015 (full-time)

Income alone does not give a full picture of living standards. **Housing** is a key aspect of inequalities; indeed, the most visible marker of areas of deprivation and affluence in Kent is the housing found in those areas. Poor quality housing is a risk to health, and rates of over-crowded accommodation and shared dwellings in Kent are strongly associated with levels of deprivation.

Private rental prices have increased [Figure 12] so that a greater proportion of pay is spent on housing. Whilst wages have been increasing recently in Kent, the increase has been below the rise in the cost of housing.

House prices have risen steadily in Kent and the average house price is now around £300,000. This is decreasing the prospects of home ownership for many, and is leading to widening inequalities.

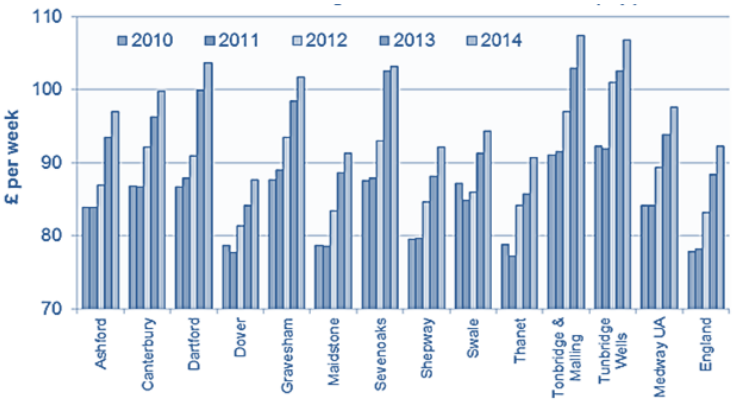


Figure 12 Private rental price changes in Kent districts 2010-2014

Fuel poverty affects the ability of individuals to live in warm housing. Cold temperatures affect the immune system, leaving elderly individuals at increased risk of infections, respiratory disease and cardiovascular disease. The fuel poverty rate in Kent was 8.6% in 2013, less than the national rate of 10.4%. The number of **excess winter deaths** in Kent dropped from 925 in 2012/13 to 589 in 2013/14.

Child poverty has reduced by 1% in the last year, but still 16.5% of all children in Kent live in poverty. While below the national average of 18% this nonetheless constitutes over 50,000 children in Kent living in poverty. Over two thirds of the children in Kent living in poverty live with a lone parent.

Certain vulnerable groups in Kent are more susceptible to poorer health. **Rough sleepers**, who lack food, shelter, and warmth, are at risk of a wide range of health problems. The lack of an address makes it difficult for this group to register with a GP and access primary health care services, leading to an overreliance on acute health care services, such as A&E.

Homelessness can also be more hidden in the form of temporary accommodation (sofa surfing, squatting, hostels, B&Bs). This transient living can lead to poor continuity of care and service provision. In Kent, the number of households accepted as homeless and in priority need has been increasing since 2010.

Think Housing First

The impact of housing on the population's health is significant and crucial. Modern legislation continues to address many of the issues brought up in the 1840 select committee report on the health of our towns. However, the challenges faced by some households to secure good quality, safe, accessible, affordable homes has resulted in a necessary range of public and voluntary sector organisations working across the sector through a variety of programmes and interventions, including:

- New affordable housing provision
- Interventions to ensure homes are safe, warm including actions arising from HHSRS (health & housing safety rating system) assessments
- Housing assistance through grants or loans, including Disabled Facilities Grants to make homes accessible for disabled and frail adults and children
- Homelessness prevention for vulnerable households
- Emergency accommodation where homelessness can't be prevented
- Housing related support
- Landlord licensing and accreditation schemes to ensure at least minimum standards are met

Joint Policy and Planning Board, together with Kent Housing Group, has developed a strategy, *Think Housing First*, which recognises the impact of housing on health inequalities. All objectives within the Think Housing First action plan support the six main policy objectives of the Marmot Review. Each of the housing related actions within the plan have been designed in partnership with all of the appropriate organisations, to ensure commitment to improve health outcomes and deliver added value to the above work programs for the benefit of Kent residents.

E) Create and develop healthy and sustainable places and communities

Creating a physical environment in which people can lead healthier lives is crucial to tackling health inequalities. **Green spaces** such as parks, woodland and other open spaces are associated with a number of health outcomes, relating to physical health, mental health and general wellbeing. There are many indirect benefits too, for example, providing space for social activity, sports and recreation, and improving the air quality. [Figure 13] shows how **'Living Environment'** varies across Kent by deprivation, with worse scores in more deprived areas.

The Kent countryside, the 'garden of England' is a great asset for the county, economically, culturally and socially, and green space constitutes 85% of the land area in Kent.

It is important to understand how such assets can be used to promote healthy physical activity. Currently, 28.4% of adults in Kent are **physically inactive**, being active for less than 30 mins per week, when the national recommendation is for 150 minutes per week.

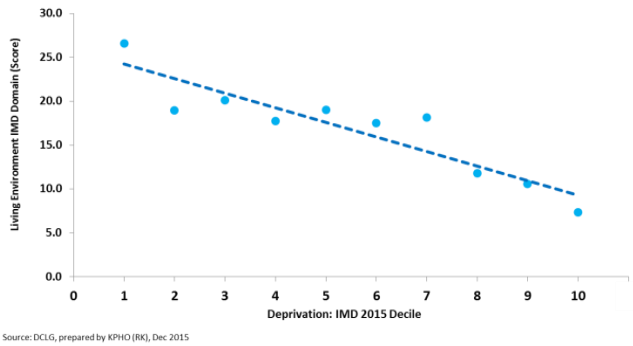


Figure 13 **Living Environment scores by deprivation in Kent, 2011**

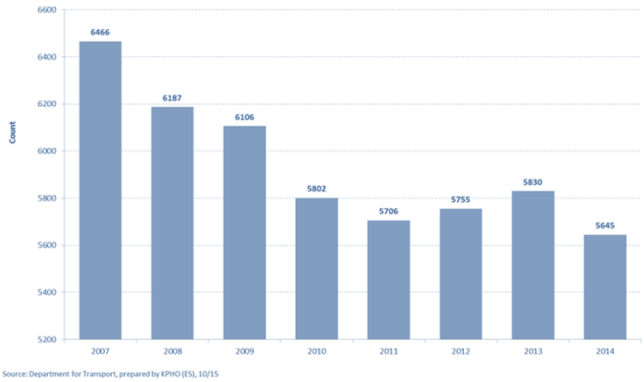


Figure 14 Casualties on Kent roads 2007-2014

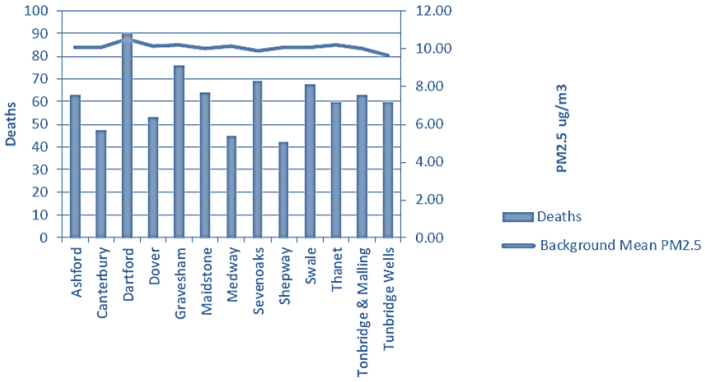


Figure 15 Deaths per 100,000 due to air pollution from fine particulate matter (PM2.5) in Kent, 2011

The impact of **transport** on health is complex and multifactorial – increasing access to work and services, but also contributing to greenhouse gas emissions, physical inactivity and outdoor noise and air pollution. Use of public transport eases traffic congestion, increases physical activity and reduces gas emissions. 71% of Kent residents travel to work by car.

Road traffic injuries are a significant public health concern as a major avoidable cause of death, particularly among children and young people. The number of casualties from road traffic accidents has decreased in Kent in recent years [Figure 14].

Poor air quality is another concern that drives health inequalities and premature mortality from cardio-respiratory diseases. Using background readings of fine particulate matter (PM2.5) in the air, we can estimate the number of related early deaths that occur each year in Kent [Figure 15]. Air pollution tends to be worse close to busy roads, where poorer communities often live.

The Marmot Review proposes that reducing health inequalities and **environmental sustainability** go together. Creating communities with a focus on real wellbeing aligns well with the climate change agenda, by creating the conditions that enable everyone to flourish in a way that is sustainable.

As well as natural assets, Kent has a rich cultural heritage, and Kent is now part of a national pilot programme to facilitate the commissioning of the **arts and culture** for public health. Twelve arts and cultural organisations are now working with existing mental health providers to deliver a range of activities, with further plans to engage eight local reading, singing, writing and dance groups.

Smoke Free Parks

The aim of this pilot project in Ashford and Canterbury is to encourage self-enforced smoke free zones in areas where children play, in order to reduce their exposure to second hand smoke. The signage has been co-designed and created by local people. Details of local stop smoking services are also included in the signs, to signpost individuals who may benefit from these services. The local response has been very positive.

Outdoor Gyms

Gym membership can be prohibitively expensive. Outdoor gyms, common in other countries, can be used as a free resource to encourage physical activity and getting outdoors. Most existing outdoor gyms are in affluent areas in Kent. KCC funded outdoor gyms in Sherwood and Gravesend, together with instructor-led sessions, and have received positive feedback from service users.

Live Well Kent

'Live It Well' is Kent's mental health and wellbeing strategy. This gave priority to promoting wellbeing as a cost effective preventative intervention, and placed particular focus on tackling health inequalities by targeting those groups at risk of poor wellbeing and low resilience. Public Health commissioned a series of targeted projects between 2013 and 2015, using an asset-based approach to improve wellbeing across the county, ranging from Men's Sheds to Creative Arts Projects. Part of the programme was a communications campaign that encouraged people to adopt behaviours that can improve their mental wellbeing. This can be summarised into six simple steps: 'The Six Ways to Wellbeing' (below), which are based on research by the New Economics Foundation. The learning from this programme will feed into a new Community Mental Health and Wellbeing Service called 'Live Well Kent'. The service began in April 2016 and is a free service for anyone over 17 living in Kent. More information can be found at: http://livewellkent.org.uk/

©SLaM

Body: be active
Mind: keep learning
Spirit: give
People: connect
Place: take notice
Planet: care

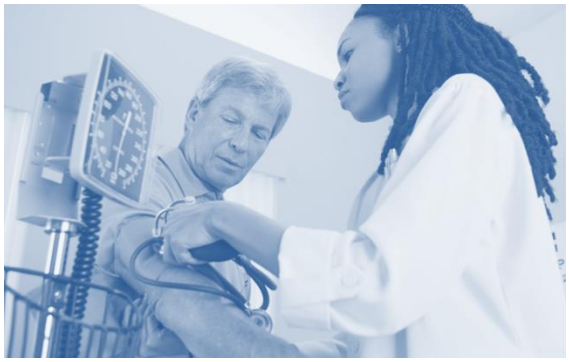
Kent Sheds

Social isolation becomes more common as we age. This Kent-wide initiative provides the opportunities for men to participate in practical group activities such as engineering projects, woodworking or gardening. Here, they can share and learn new skills, and support one another by working together 'shoulder to shoulder', thereby developing friendships. The aim of the programme is to increase population wellbeing, reduce risk of suicide, and aid and improve resilience. There are currently 27 sheds across Kent, and the initiative supports groups and organisations to set up their own 'sheds'. Feedback is very positive, with 91% of participants reporting improved wellbeing. More information can be found at http://www.kentsheds.org.uk/

F) Strengthen the role and impact of ill health prevention

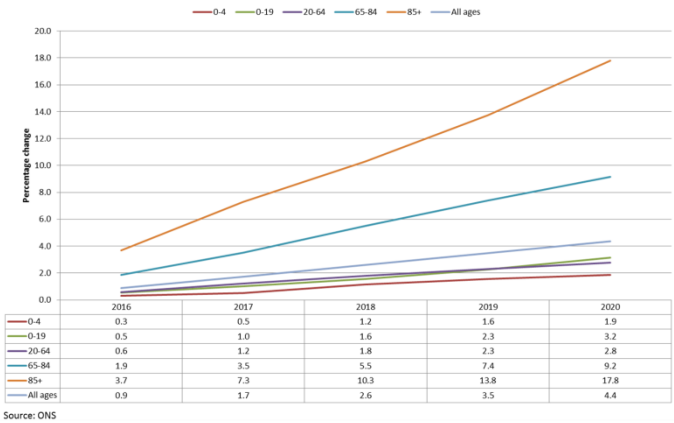
The previous policy objectives of the Marmot review focus on the social determinants of health, the most upstream underlying causes of health inequalities. Yet there are also interventions that can happen more downstream to promote healthy behaviour and ill health prevention, across the NHS, local government and communities. For example, Making Every Contact Count (MECC) is a national programme to ensure all NHS staff are trained to engage in conversations about healthier lifestyles. **Smoking** prevalence in Kent has been decreasing, from 21.7% in 2010 to 19.1% in 2014. Rates of **obesity**, as for smoking, are higher in more deprived areas in Kent. Premature mortality caused by **alcohol** is six times higher in the most deprived areas compared to the most affluent areas.

The **NHS Health Check** programme is a national cardiovascular screening programme for all individuals aged 40-74 who are not already being treated for cardiovascular disease. Since CV disease will affect many people as they age getting this five-yearly check of blood pressure, weight and cholesterol is a way of identifying risks and



getting advice and support to change lifestyles for the better. The proportion of the eligible population receiving a Health Check in Kent is 17.4%, compared to 18.6% nationally. Healthcare advances over the decades mean that we are all living longer; mortality rates have fallen across the board in Kent, and we have an **ageing population** [Figure 17].

However, we are also spending a greater proportion of our lives in ill health, and more deprived populations in Kent face a greater degree of **long term disability** [Figure 16], which reduces the ability to work and enjoy life. Addressing this is one of the great challenges facing not only public health, but also the wider Kent economy; 7.6% of residents claim some form of disability benefit.



	2016	2017	2018	2019	2020
0-4	0.3	0.5	1.2	1.6	1.9
0-19	0.5	1.0	1.6	2.3	3.2
20-64	0.6	1.2	1.8	2.3	2.8
65-84	1.9	3.5	5.5	7.4	9.2
85+	3.7	7.3	10.3	13.8	17.8
All ages	0.9	1.7	2.6	3.5	4.4

Source: ONS

Figure 17 Projected population changes in Kent from 2015 to 2020 by age group

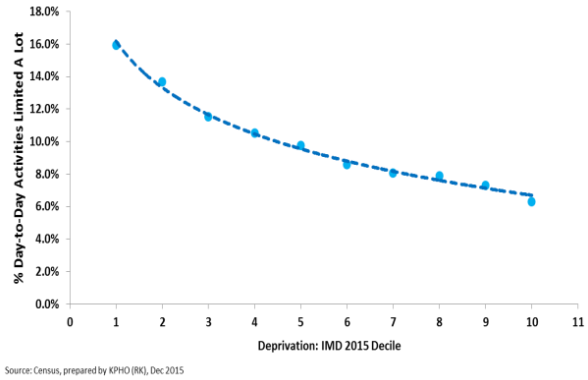


Figure 16 Long term illness and disability in Kent by deprivation, 2011

Managing the growing burden of chronic disease will require us all to lead healthier lifestyles, and better self-manage chronic conditions at home and in the community.

However, deprived populations have lower rates of uptake of preventative health services. A key challenge for **primary care** in addressing health inequalities is to reach out to deprived communities to make sure they are registered and aware of the services available. A number of initiatives aim to increase awareness of and engagement with Health Improvement services (below).

End-of-life care is another area which exhibits inequalities in healthcare provision, as deprived populations are less likely to receive specialist palliative care. Surveys indicate that people overwhelming prefer to die in their own homes, yet nearly half of all deaths in Kent still occur in hospital. This figure is decreasing with better end of life care planning. All of us have the right to a good death. This issue has been recognised by Kent CCGs who are taking a whole population approach to improving pathways for the end of life across acute and community care.

Health MOT Roadshow

This is a free mobile health initiative in Maidstone, designed to engage with harder-to-reach individuals and signpost to health services. A branded mobile health unit, with an 'Interactive Health Kiosk' inside, is used by the team in a variety of outreach settings, such as shopping centres, supermarkets, community centres, and places of worship. The Interactive Health Kiosk allows individuals to self-test key indicators such as: weight, body mass index, body fat content, heart rate and blood pressure. Each 'Health MOT' is performed in around five minutes, and can lead to referrals or signposting to services to better manage these risk factors.

Making Every Contact Count

Making Every Contact Count is a national programme to better train and support health professionals to deliver lifestyles advice to promote health. This ranges from brief advice, to more advanced behaviour change techniques and signposting towards support and services. We are now expanding MECC to sectors outside of health, as everyone who comes into contact with members of the public has the opportunity to begin conversations about health. Kent, Surrey and Sussex are currently piloting a MECC e-learning programme and two day training session with Housing providers in Kent, using funding provided by Health Education England.

Healthy Living Pharmacies

The HLP programme aims to support pharmacies to promote healthier lifestyles and behaviour change and through commissioned public health services. To date 111 pharmacies have registered to become HLPs, and 173 Health Champions have been trained in total. Many pharmacies are now undergoing a process of accreditation. With increasing pressure and demand on the health service, pharmacies have a key role to play improving the health and wellbeing and helping to reduce health inequalities in local

4 Life Expectancy and Deprivation

The more affluent you are, the longer you are likely to live, and this phenomenon is as true in Kent as it is across England and around the world. The health inequalities discussed throughout this report accumulate throughout life as we age, resulting in worse health outcomes in the most deprived populations. Figure 18 shows how the most deprived decile populations in Kent have a disproportionately lower life expectancy, considerably worse than even the slope gradient. We can map geographically the locations of these populations that feature in the most deprived decile in Kent [Figure 19].

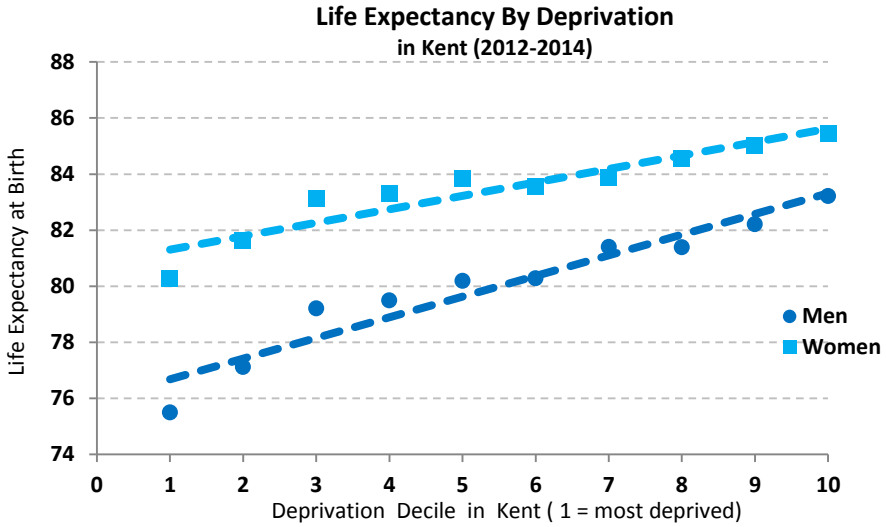


Figure 18 Life expectancy in Kent by deprivation decile

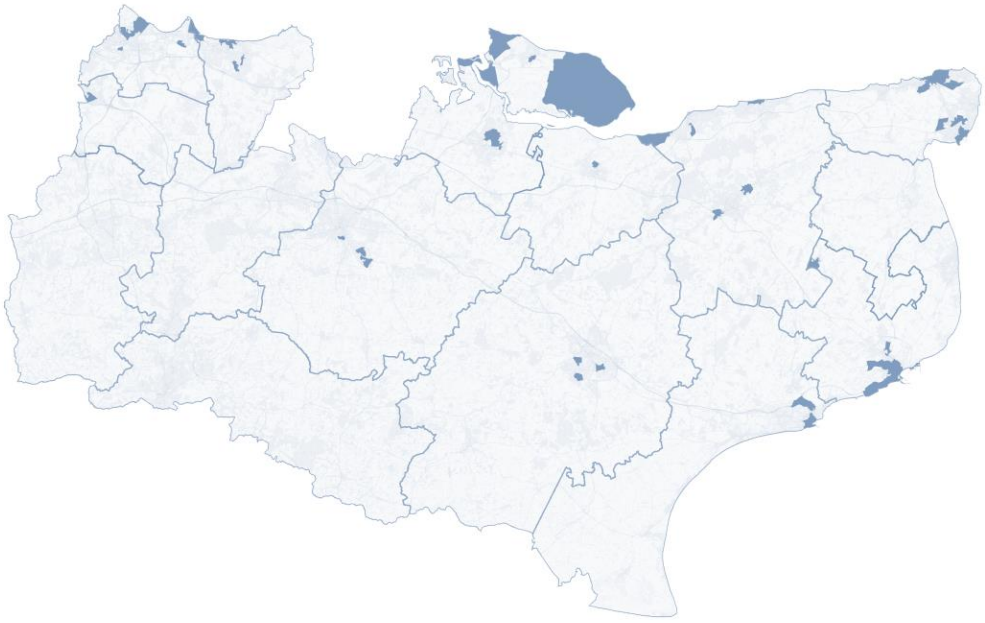


Figure 19 The 88 most deprived areas in Kent by IMD 2015 (Indices of Multiple Deprivation)

5 The Way Forward

Health needs in Kent are disproportionately greater in the most deprived populations, and we have mapped these populations geographically across Kent [Figure 19]. Closing the 'health gap' will require a faster improvement in health in these areas, so moving forward we will need to better engage with these communities at a local level to improve both wellbeing and health outcomes. Central to this approach is recognising the inherent skills, capabilities and talents of Kent's communities, empowering local people to own the solutions to developing thriving, healthy and sustainable communities. This approach requires action both within and outside of the health sector, and therefore will require collaborative partnerships between the County Council departments, District Councils, CCGs, healthcare providers, and community partners [Figure 20]. Tackling health inequalities in Kent is a task that will require the efforts of all: across multiple organisations and within communities themselves.

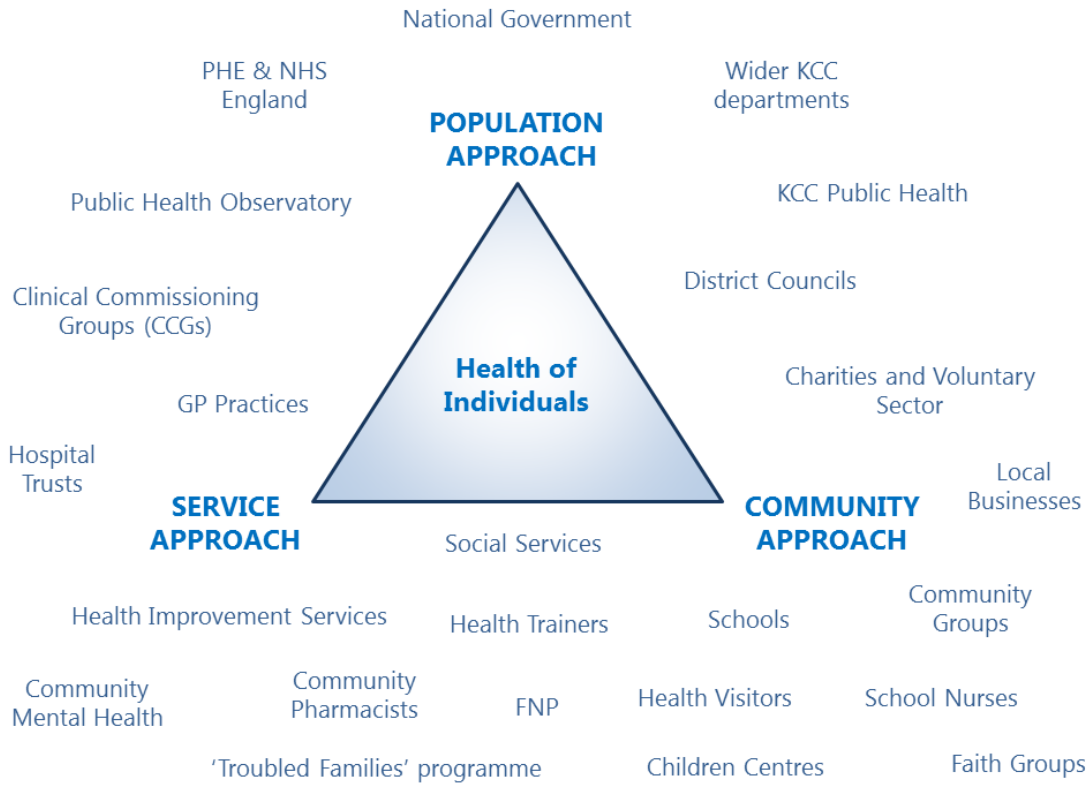


Figure 20 **Examples of stakeholders and partners that can impact on health**

Appendix 1: Health Inequality Indicators for Kent

Data from Public Health England Fingertips: http://fingertips.phe.org.uk/

Kent significantly better than national rate = Green
Kent significantly worse than national rate = Red
Kent not significantly different from national = Yellow

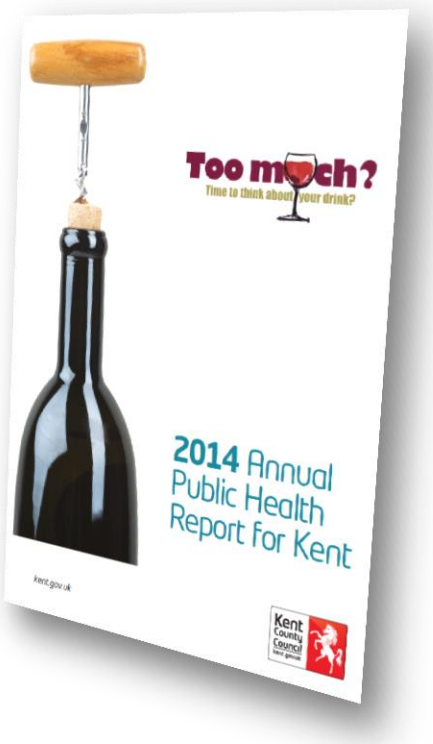
Lifecourse Stage	Indicator	Indicator Description	National (latest)	Kent (prior)	Kent (prior)	Kent (latest)	Kent Trend	Latest Data Period
INFANCY	Infant Mortality	Infant mortality (rate per 1000 live births)	4.0	-	3.2	2.9		2011-2013
	Smoking in Pregnancy	Smoking status at time of delivery (as % of maternities)	11.4%	15.2%	13.0%	12.6%		2014/15
	Breast Feeding	Breast feeding initiation (as % of maternities)	74.3%	72.1%	71.3%	71.3%		2014/15
	Teen pregnancy	Under 18 Conceptions (rate per 1,000 females aged 15-17)	22.8	24.3	22.9	22.2		2014
	Immunisations	Population vaccination coverage - MMR for 2 doses by 5 years of age (%)	88.6%	92.2%	87.1%	82.4%		2014/15
	Childhood Development	School readiness: % of children achieving a good level of development at the end of reception	66.3%	63.4%	68.5%	72.9%		2014/15
	Childhood Development (FSM)	School readiness: % of children with FSM status achieving a good level of development at the end o	51.2%	47.7%	51.8%	58.8%		2014/15
	Childhood Obesity (YR)	Overweight children (4-5 years) (% of children overweight or obese)	21.9%	21.7%	20.8%	22.5%		2014/15
CHILDHOOD	Childhood Obesity (Y6)	Overweight children (10-11 years) (% of children overweight or obese)	33.2%	32.6%	32.7%	32.8%		2014/15
	Childhood Poverty	Childhood Poverty (% of children under 16 in low income families)	18.6%	18.3%	17.6%	17.3%		2013
	Education (attendance)	Pupil Absence (% half days missed due to unauthorised/authorised absence 5-15yr olds)	4.51%	5.27%	5.30%	4.70%		2013/14
	Education (attainment)	GCSE Attainment (% achieving 5 good GCSEs A*-C including English and Maths)	56.8%	-	-	58.0%	-	2013/14
	Education (attainment)	16-18 year olds not in education, employment or training - NEET (%)	4.7%	6.4%	5.8%	4.7%		2014
	Childhood smoking	Percentage of current smokers - age 15	8.2%	-	-	10.5%	-	2014/15
	Childhood alcohol	Percentage of regular drinkers - age 15	6.2%	-	-	6.1%	-	2014/15
	Childhood wellbeing	Childhood wellbeing (percentage reporting low life satisfaction age 15)	13.7%	-	-	13.4%	-	2014/15
	Childhood mental health	Child admissions for mental health - per 100,000 aged 0-17 years	87.4	150.2	117.5	84.4		2014/15
	Looked-after children	Looked After Children - rate per 10,000 under-18 yrs population	60.0	56.0	56.3	57.0		2014/15
	Childhood injuries	Hospital admission caused by injuries in children (aged 0-14 years) per 10,000 population	112.2	111.0	95.3	100.1		2013/14
	Young people drug-use	Hospital admissions due to substance misuse (aged 15 - 24) ASR per 100,000	88.8	79.8	96.1	104.9		2012/13-14/1
	Young people self-harm	Hospital admissions as a result of self-harm (aged 15 - 24) ASR per 100,000	398.8	360.5	411.7	372.5		2014/15
	Young people offences	First time entrants to the youth justice system, rate of 10-17 year olds per 100,000 population	409	583	515	449		2014
ADULTS	Unemployment	Unemployment (% of working age population)	6.2%	-	7.4%	5.4%		2014
	Unemployment	Longterm Unemployment (per 1000 of working age population)	7.1	7.3	7.7	5.6		2014
	Employment Gap (LD)	Gap in employment rate between those with a learning disability and the overall employment rate	66.9%	65.2%	66.3%	65.0%		2014/15
	Employment Gap (MH)	Gap in employment rate between those in secondary mental health services and the overall emplyr	66.1%	64.0%	66.5%	68.3%		2014/15
	LD support & independence	Adults with a learning disability who live in stable and approriate accomodation (%)	73.3%	70.1%	70.0%	72.4%		2014/15
	MH support & independence	Percentage of adults in contact with secondary mental health services in stable/appropriate accomc	59.7%	81.5%	77.6%	75.3%		2014/15
	Homelessness	Statutory Homelessness Acceptances (per 1000 households)	2.4	1.8	1.5	1.9		2014/15
	Domestic Abuse	Domestic Abuse (18+ years) recorded police incidents per 1000 population	18.8	16.4	16.9	17.3		2012/13
	Violent Crime	Violent crime (violence offences, crude rate per 1000 population)	13.5	10.7%	14.3	15.6		2014/15
	Healthy Eating	Proportion of population meeting the recommended '5-a day'	53.5%	-	-	56.2%	-	2014
	Healthy Weight	Excess weight: excess weight in adults	63.8%	-	-	64.6%	-	2012
	Physical Activity	Physical Inactivity (<30mins per week of moderate activity)	27.7%	27.5%	26.8%	28.4%		2014
	Green Space	Utilisation of outdoor space for exercise/health reasons (%)	17.1%	13.4%	10.7%	12.1%		2013/14
	Smoking	Smoking prevalence in adults (%) (from integrated household survey)	18.0%	20.9%	19.0%	19.1%		2014
	Smoking	Quit rate from Stop Smoking Services (%)	51.0%	-	52.1%	54.0%		2014/15
	Alcohol	Admission episodes for alcohol-related conditions (Broad) (ASR per 100,000)	2111	1602	1625	1695		2013/14
	Wellbeing	Self-reported well-being: % of people with a low happiness score	9.0%	9.90%	9.0%	10.1%		2014/15
	Depression	Adults with depression known to GPs (QOF prevalence)	6.5%	-	-	6.4%	-	2013/14
	Road Injuries	Killed and seriously injured on roads, crude rate per 100,000	39.3	36.1	36.9	39.6		2012-14
ELDERLY	Fuel Poverty	Fuel Poverty - households that experience fuel poverty (%) (low income, high cost methodology)	10.4%	9.0%	8.5%	8.6%		2013
	Winter Deaths	Excess winter deaths index (single year, all ages/persons)	11.6	15.2	21.8	13.8		2013/14
	Flu Vaccination	Population vaccination coverage - Flu (aged 65+) %	72.7%	71.4%	71.1%	70.9%		2014/15
	Falls	Injuries due to falls in people aged 65 and over (ASR per 100,000)	2125	2096	2224	2201		2014/15
	Hip Fractures	Hip Fractures in people aged 65 and over (ASR per 100,000)	571	544	581	598		2014/15
	Readmissions	Emergency readmissions within 30 days of discharge from hospital (Persons)	11.8	11.5	11.7	11.9		2011/12
	Health Checks	Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	18.6%	-	-	17.4%	-	13/14-2014/
	Cancer Screening (Breast)	Cancer Screening Coverage - Breast Cancer - % of eligible women screened in prior 3 years	75.4%	78.2%	77.6%	77.0%		2015
	Cancer Screening (Cervical)	Cancer Screening Coverage - Cervical Cancer - % of eligible women screened in prior 3.5 or 5.5 years	73.5%	77.2%	77.1%	77.1%		2015
	Cancer Screening (Bowel)	Cancer screning coverage - bowel cancer - % of eligible people screened in previous 2.5 years	57.1%	-	-	58.1%	-	2015
	End of Life Planning	Percentage of deaths that occur in Usual Place of Residence	44.7%	47.0%	45.4%	46.2%		2014
MORTALITY	Premature Mortality	Premature mortality from all causes (ASR per 100,000)	337	-	322	318		2012-2014
	Premature Mortality (cardio)	Under 75 mortality rate from cardiovascular disease considered preventable (ASR per 100,000)	49.2	52.3	49.3	46.0		2012-2014
	Premature Mortality (resp)	Under 75 mortality rate from respiratory disease considered preventable (ASR per 100,000)	17.8	16.6	16.7	16.5		2012-2014
	Premature Mortality (cancer)	Under 75 mortality rate from cancer considered preventable (ASR per 100,000)	83	81.5	79.3	78.4		2012-2014
	Premature Mortality (liver)	Under 75 mortality rate from liver disease considered preventable (ASR per 100,000)	15.7	12.4	13.2	13.7		2012-2014
	Air-pollution-related Mortality	Fraction of mortality attributable to air pollution (PM2.5) (% of all age all cause mortality)	5.3%	5.4%	5.0%	5.4%		2013
	Communicable Disease Mortality	Mortality from communicable disease (ASR per 100,000)	63.2	72.6	69.3	64.4		2010-2012
	Smoking-related Mortality	Smoking-related deaths (ASR pr 100,000)	274.8	276.6	272.6	266.7		2012-2014
	Alcohol-related Mortality	Alcohol-related mortality (ASR per 100,000)	45.5	43.4	44.8	42.4		2014
	Suicide	Suicide age-standardised rate per 100,000 (3 year average)	8.9	8.1	9.2	10.2		2012-14
	Preventable Mortality	Mortality rate from causes considered preventable	182.7	176.0	172.5	169.8		2012-2014
	Healthy Life Expectancy (male)	Health life expectancy at birth - years expected in good health (males)	63.3	63.6	63.5	62.8		2011-2013
	Helathy Life Expectancy (female)	Health life expectancy at birth - years expected in good health (female)	63.9	65.5	66.0	66.4		2011-2013
	Life Expectancy (male)	Life expectancy at birth - years (male)	79.5	79.9	79.9	80.1		2012-2014
	Life Expectancy (female)	Life expectancy at birth - years (female)	83.2	83.4	83.6	83.6		2012-2014
	Life Expectancy Gap (males)	Slope index of inequality in life expectancy at birth based on local deprivation deciles - years (males	9.2	7.1	7.1	7.4		2012-2014
	Life Expectancy Gap (females)	Slope index of inequality in life expectancy at birth based on local deprivation deciles - years (fema	7.0	4.8	5.1	4.4		2012-2014

Appendix 2: Progress on Alcohol Strategy

Last year's Public Health Annual Report addressed the topic of alcohol. Good progress has been made towards achieving the aims within the six pledges of the Kent alcohol strategy for 2014-16. For example we aimed to screen 9% of the population by the end of 2016 and offer advice on reducing alcohol related harm. By the start of 2016, we had screened 11% and expect this to increase throughout 2016.

Each district now has a local alcohol action plan to tackle alcohol-harms in their communities. These plans link together with other partnership groups such as Community Safety Partnerships and Community Alcohol Partnerships to tackle alcohol related harm in the community. The good work of Kent Community Alcohol Partnerships has been highlighted by two Ministerial visits in north Kent during 2015. A web-based screening and advice tool, 'Know Your Score', was launched in January 2016. This is proving very popular – over 2500 people took the test and received advice in the first week it was launched! There has been fewer hospital admissions for the under 18s and work continues to reverse the increasing trends for alcohol-related illness and mortality in the Kent population.

Pledge	Action
Improve prevention and identification	We aim to screen 9% of the Kent population by the end of 2016 with Identification and Brief Advice (IBA) We will increase the number of partner organisations (or public service staff including community and voluntary groups) trained to conduct IBAs
Improve the quality of treatment	We will increase the number of people successfully completing alcohol treatment
Coordinate enforcement and responsibility	We will increase the number of Community Alcohol Partnerships in Kent, working closely with the Community Safety Partnerships. We aim to increase the number of Community Alcohol Partnerships in Kent
Tailor the plan to local communities	Each local authority area will receive an updated substance misuse needs assessment and detailed information on alcohol use trends for their area to help them develop a local Alcohol Action Plan
Target vulnerable groups and tackle health inequalities	We will work with partners such as sexual health services providers and housing associations to target support at vulnerable people
Protect children and young people	We will continue to provide education and treatment services to children and young people We aim to reduce alcohol related hospital admissions for under 18 year olds



New Alcohol Guidelines

- Both men and women are now advised not to regularly drink more than **14 units per week**.
- **Spread the units** throughout the week, limiting the amount you drink in one session, and include some **drink-free days** per week.
- If you are **pregnant** or planning pregnancy, the safest option is not to drink alcohol

Annual Public Health Report 2015

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