KENT PUBLIC HEALTH OBSERVATORY

Clinical network profile: Ashford CCG

Rural network

February 2016

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| 1. Executive Summary

1.1   Introduction

This clinical network profile for Rural clinical network in Ashford CCG was put together from a variety of source information and data. It seeks to pull together a wide range of intelligence from Health & Social Care, as well as key demographic data from the Office for National Statistics, and present an overview of local need.

The area called the Rural clinical network was defined through discussion with the local clinical commissioning group and forms one of three networks within the Ashford CCG area.

1.2   Key Findings

Maternity

- **Life expectancy at birth**

Within the Rural clinical network within 2012-2014, a new-born male baby could be estimated to survive an average of 83.3 years and is higher than Kent at 80.9 years. Also, a new-born female baby could be estimated to survive an average of 84.6 years and is similar to Kent at 84.1 years. The trend in male life expectancy has increased, whereas, female life expectancy has been stable within the Rural Clinical network between 2006-2008 and 2012-2014.

- **General fertility rate**

The wards within Rural clinical network all have lower GFR than Ashford CCG, the highest being Tenterden North (63.4). A number of wards have GFR which are significantly lower than both the CCG and Kent; Tenterden South, Weald South, Weald Central and St Michaels.

- **Low birth weight**

Within the network, the percentage of births with a low birth weight range from 1.3% in St Michael's ward to 7.5% in Romney Marsh; however none of the wards have significantly different percentages to either Ashford CCG or Kent.

- **Infant feeding**

As a clinical network, Rural (53.1%) has a lower coverage than Ashford CCG (59.7%), which in turn is lower than Kent (70.7%). Whilst the prevalence of breastfeeding at 6 to 8 weeks is lower in Ashford (26.2%) than Kent (33.5%), Rural has a slightly higher prevalence than the CCG, at 28.6%.

- **Immunisations**

As a clinical network, Rural has uptake below then 90% threshold for PCV (12 month), Hib.MenC.Booster and PCV.Booster (24 months), and DTaP.IPV.Booster and MMR.2nd.dose (5 years).

- **Infant mortality**

Rural clinical network has a lower mortality rate for all indicators with the exception of post neonatal mortality; however, none of the differences observed are significant.

Demographic overview

- **Practice population**

Within the Rural clinical network, there were over 10,000 persons aged 55 years and over, contributing 42.0% to the total population. Also, a lower proportion of the population were aged under 40 years.

- **Ethnicity**

All of the wards within the Rural clinical network had lower proportions of ethnic minority groups in comparison to Ashford CCG.

Socio-economic profile

- **Deprivation**

None of the practices in Rural Clinical Network have an Indices of Multiple Deprivation (IMD) score above the England average, and only Ham Street Surgery has a score above Ashford CCG.

Ashford CCG has a lower proportion of children living in income deprived households (17.1%) in comparison to Kent (19.9%). The practices in Rural clinical network have markedly lower proportions of children living in income deprived households, the highest being Ham Street Surgery, with 12.7%.

Ashford CCG has a lower proportion of older people living in pension credit (guarantee) households (12.9%) in comparison to Kent (16.2%). The three practices within Rural Clinical Network have low percentages of older people living in pension credit (guarantee) households, the highest being in Woodchurch Surgery at 10.9%.

Lifestyle

- **Alcohol, Obesity & Smoking**

Binge drinking prevalence is greatest (16% to 20%) in the more populous wards towards the centre of Ashford. The rates in the rural northern areas are very slightly higher than those in the rural south of Ashford (with the exception of Tenterden).

The higher prevalence of adult obesity is found in the south eastern areas of Ashford town. The lowest prevalence is located toward the north western electoral wards of the district.

Smoking prevalence in Ashford is greatest in Washford, Stanhope and Beaver wards, other central town centre wards also have high prevalence's of adult smoking. The rural areas of the district have prevalence levels that are almost half those of the urban central wards.

Mental health

- **Contact with services**

Within Rural clinical network, the mental health contact rate for people aged 15 to 64 ranges from 25.5 in Isle of Oxney ward to 39.6 in Tenterden South. Weald Central and the Isle of Oxney have significantly lower rates than Kent and the CCG.

In Rural clinical network, the 65 and above mental health contact rate ranges from 40.6 per 1,000 population in Biddenden to 102.0 in Rolvenden and Tenterden West. Rolvenden and Tenterden West ward has a significantly higher rate than Ashford CCG and Kent, whilst the Isle of Oxney and Biddenden have significantly lower rates.

Quality outcomes framework

- **Recorded prevalence**

In 2014/15 Ashford Rural network had significantly higher prevalence of the following conditions in comparison to Ashford CCG: Atrial fibrillation, Asthma, Cancer, Coronary heart disease, Dementia, Diabetes, Hypertension, Learning disability and Obesity. In 2014/15 Ashford rural network recorded no conditions with a prevalence significantly lower than the average rate for Ashford CCG.

- **Recorded prevalence: trend analysis**

Between 2006/07 and 2014/15, Rural clinical network had a significantly higher rate of change for hypertension, cancer, atrial fibrillation and CHD, and a significantly lower rate of change for obesity.

- **Recorded and expected prevalence**

Ashford Rural has identified 86.9% of the expected number of atrial fibrillation cases, slightly lower than the CCG (91.3%) average. Percentage of expected COPD diagnosed across the Rural Network averages at 66.3%, this is lower than both Ashford (70.4%) and Kent (71.1%).

- **Clinical achievement (see appendix A for definitions)**

In 2014/15 Ashford Rural network had significantly higher clinical achievement when compared to Ashford CCG for the following indicators: Asthma 002, COPD003, COPD004, Diabetes 003, Diabetes 007, Diabetes 009, Diabetes 014, Mental Health 002 and Stroke and TIA 003. In 2014/15 Ashford Rural network did not have any significantly lower achievements than Ashford CCG.

Hospital activity

- The rate of change for Rural (349.9, per 100,000 population) is higher than the Ashford CCG (157.9) for all emergency hospital admissions.

- There has been an increase for the rate of change of asthmatic, diabetes complications, falls and mental health emergency hospital admissions which were all higher than the relevant Ashford CCG rates.

Social services

As a CCG, Ashford has significantly lower rates of long term residential care home placements (6.7 per 10,000) and home care (5.4) users for people aged under 65 in 2013-2015 (pooled), than Kent (9.7 and 6.7 respectively). The rate of support services contacts per 10,000 population is significantly higher in Ashford CCG (15.2) than Kent (12.7).

Ashford CCG has significantly lower rates of direct payments (28.9), long term residential care home placements (49.8), and home care (102.2) contacts for people aged 65 and above than Kent.

Ashford CCG has a significantly higher enablement rate (3.5 per 10,000) than Kent (2.9), but a significantly lower rate of people using meal services (1.4 in Ashford CCG, 3.7 in Kent).

Mortality

- **All age, all-cause mortality**

Within the Rural clinical network within 2012-2014, the age standardised rate for all age all-cause mortality was 803.0 per 100,000 registered population. The trend has been stable within the Rural clinical network between 2006-2008 and 2012-2014. Whereas, the trend has been decreasing across Kent.

- **Premature mortality: cancer**

Within the Rural clinical network within 2012-2014, the age standardised rate for premature cancer mortality was 96.0 per 100,000 registered population and has decreased from 152.1 in 2006-2008. This has been decreasing at a rate of change that is greater than Kent.

- **Premature mortality: circulatory disease**

Within the Rural clinical network within 2012-2014, the age standardised rate for premature circulatory mortality was 58.5 per 100,000 registered population and has decreased from 96.9 in 2006-2008. Similarly, the trend has been decreasing across Kent. But this is not a rate of change that is greater than Kent.

2. Introduction & Objectives

2.1 Clinical Network Area

2.1.1 Clinical Network practices

The map below shows the breakdown of Rural Clinical Network into wards and then into lower super output areas (LSOA's). An LSOA is a geographical region with a minimum population of 1,000 and an average population of 1,500. There are three practices within the Rural Clinical Network.

Table 1: Practices in Rural Clinical Network

Practice Name	Code
Woodchurch Surgery	G82053
Ivy Court Surgery	G82114
Ham Street Surgery	G82186

The map below shows the location of these practices.

Ashford CCG clinical network profile, February 2016
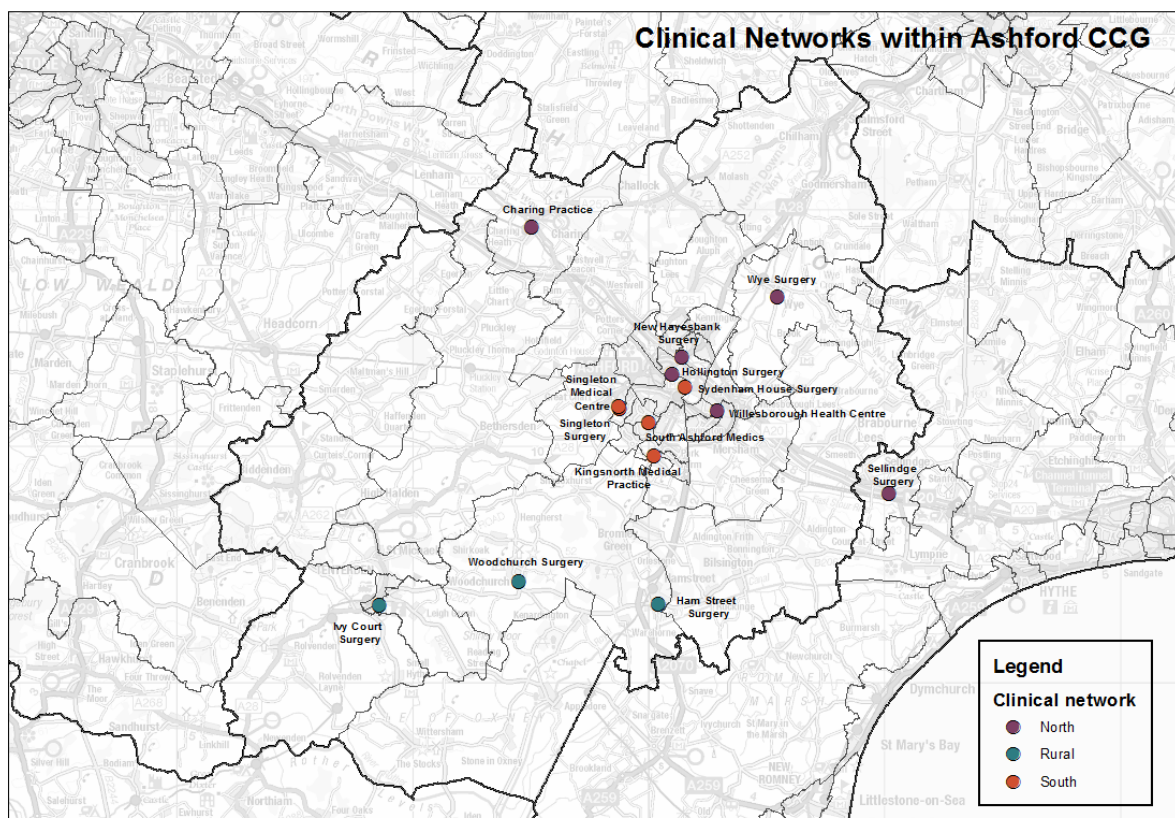
2.1.2 Clinical Network electoral wards

For some indicators, data cannot be analysed at a practice level; consequently, electoral wards have been assigned to the clinical networks. Wards have been allocated to the clinical network which has the highest percentage of the ward resident population registered within the network. In addition to the Ashford CCG wards, three South Kent Coast CCG wards have also been included due to the high numbers of residents in these wards registered to Ashford CCG practices. The following table displays the wards within Rural clinical network, and the percentage of the ward's resident population who are registered with practices within the network.

Table 2

Ward	CCG	Percentage
Biddenden	NHS Ashford	41.0
Isle of Oxney	NHS Ashford	98.9
Rolvenden & Tenterden West	NHS Ashford	89.3
Romney Marsh	NHS South Kent Coast	46.3
St Michaels	NHS Ashford	97.2
Tenterden North	NHS Ashford	98.3
Tenterden South	NHS Ashford	99.2
Weald Central	NHS Ashford	54.0
Weald South	NHS Ashford	83.6

| 3. Maternity

3.1 Life expectancy at birth

Life expectancy at birth describes the average number of years a new-born baby could be estimated to survive if he or she experienced the age specific mortality rates for that area and time period throughout life. For the clinical networks, life tables were used to calculate age specific mortality rates from the numbers of deaths within the registered population.

3.1.1 Clinical network life expectancy trend

Within the Rural clinical network within 2012-2014, a new-born male baby could be estimated to survive an average of 83.3 years and is higher than Kent at 80.9 years. Male life expectancy has increased within the Rural clinical network from 80.3 years in 2006-2008. However, this is not an increasing rate of change and is not greater than Kent.
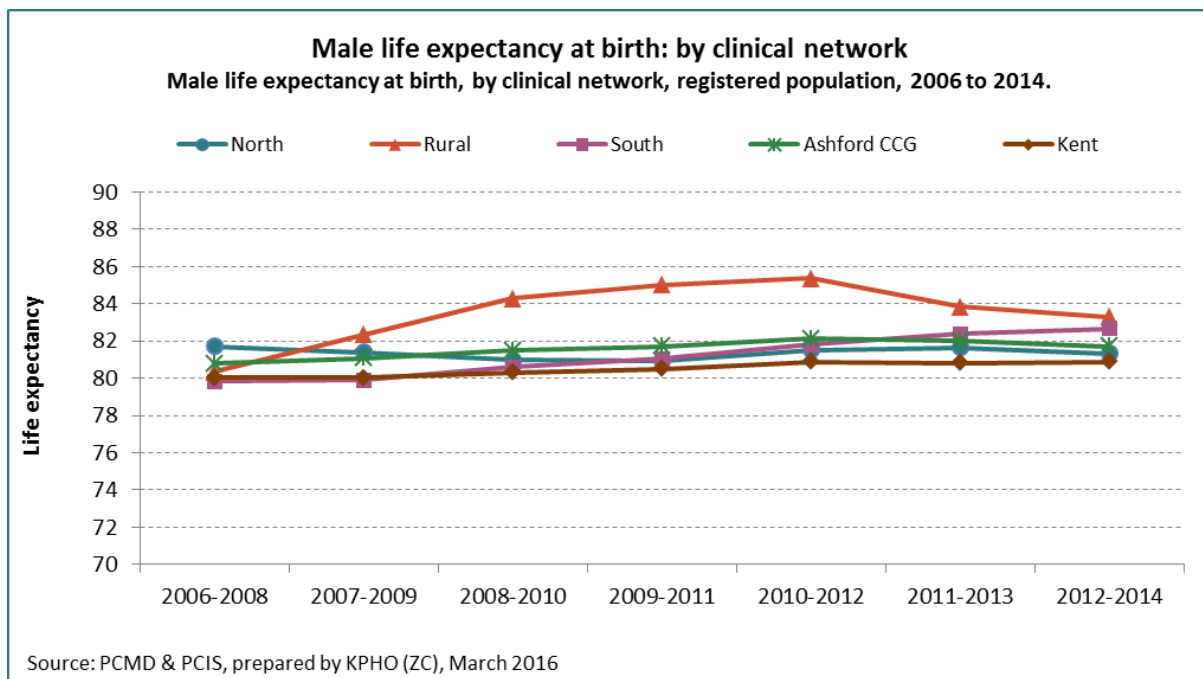
Within the Rural clinical network within 2012-2014, a new-born female baby could be estimated to survive an average of 84.6 years and is similar to Kent at 84.1 years. The trend has been stable within the Rural Clinical network between 2006-2008 and 2012-2014.

Female life expectancy at birth: by clinical network

Female life expectancy at birth, by clinical network, registered population, 2006-2008 to 2012-2014.

Source: PCMD & PCIS, prepared by KPHO (ZC), March 2016
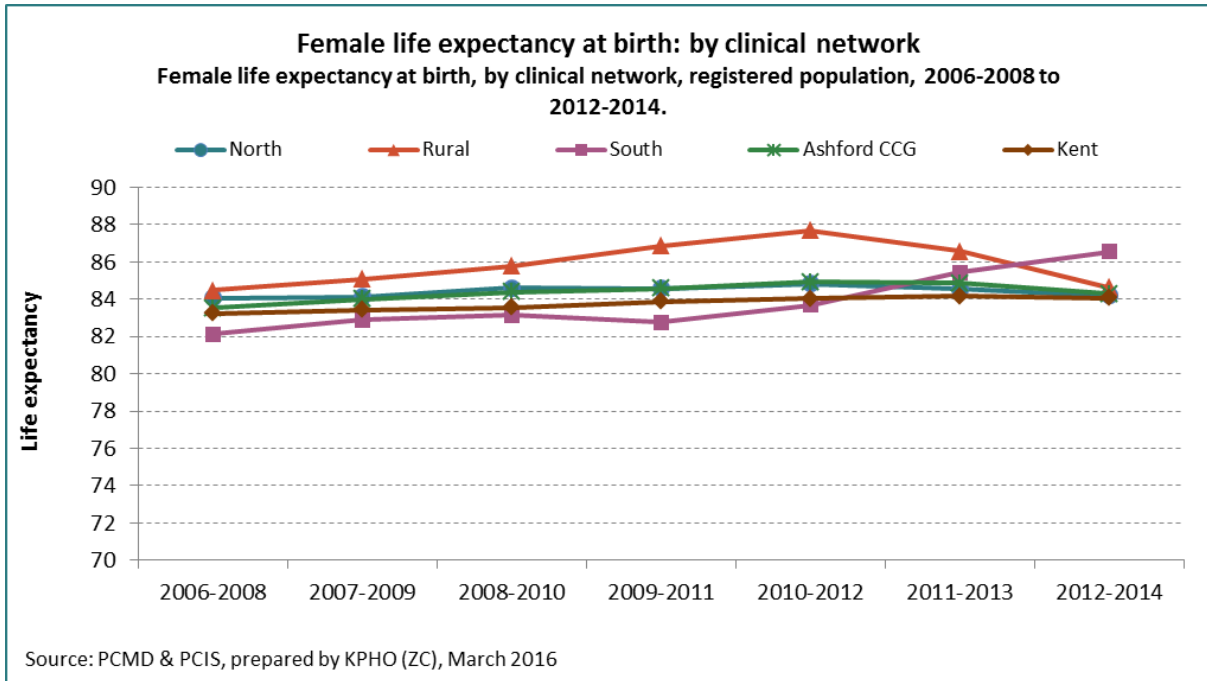
3.1.2 Practice level life expectancy

Within the Rural general practices within 2006-2014, a new-born male baby registered at Ham Street or Ivy Court could be estimated to have higher life expectancies than the Kent average. The remaining practice was similar to Kent.

Male life expectancy at birth: by general practice

Male life expectancy at birth, by general practice, registered population, pooled 2006 - 2014.

Source: PCMD & PCIS, prepared by KPHO (ZC), March 2016
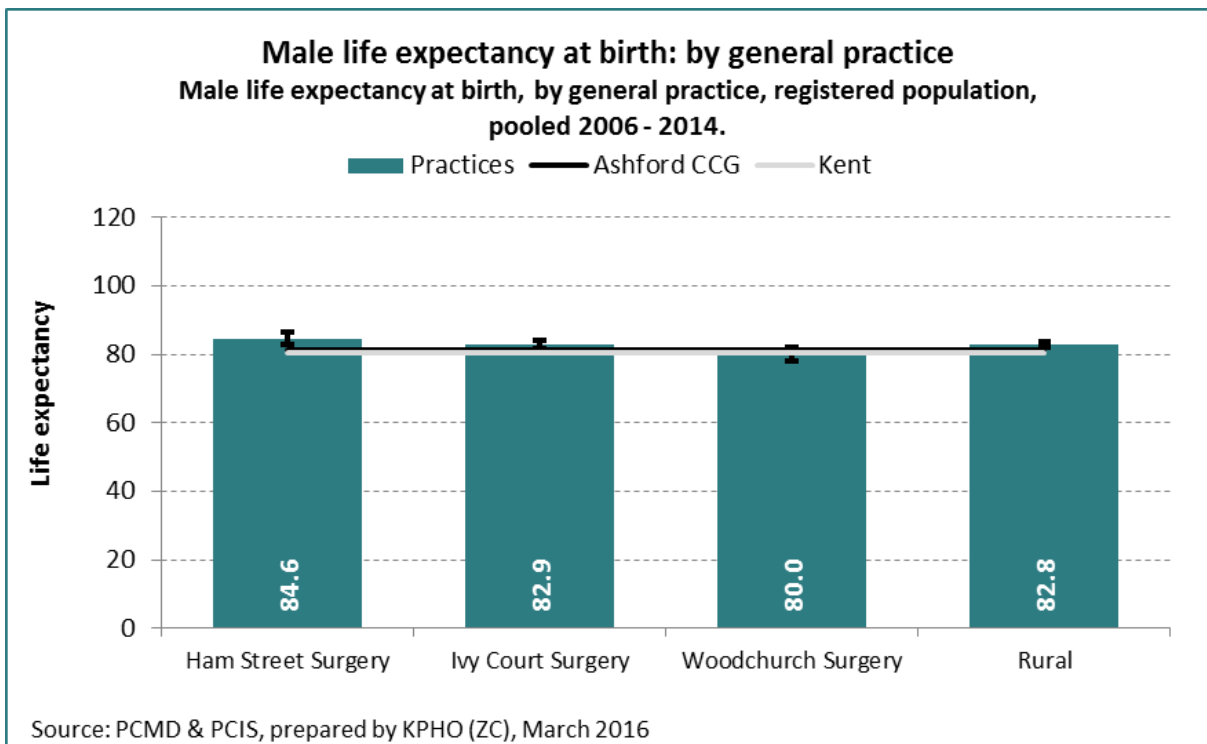
Within the Rural general practices within 2006-2014, a new-born female baby registered at Ivy Court Surgery could be estimated to have higher life expectancy than the Kent average. The remaining practices were similar to Kent.

Ashford CCG clinical network profile, February 2016

Female life expectancy at birth: by general practice

Female life expectancy at birth, by general practice, registered population, pooled 2006 - 2014.

■ Practices —— Ashford CCG —— Kent

Source: PCMD & PCIS, prepared by KPHO (ZC), March 2016

Ashford CCG clinical network profile, February 2016
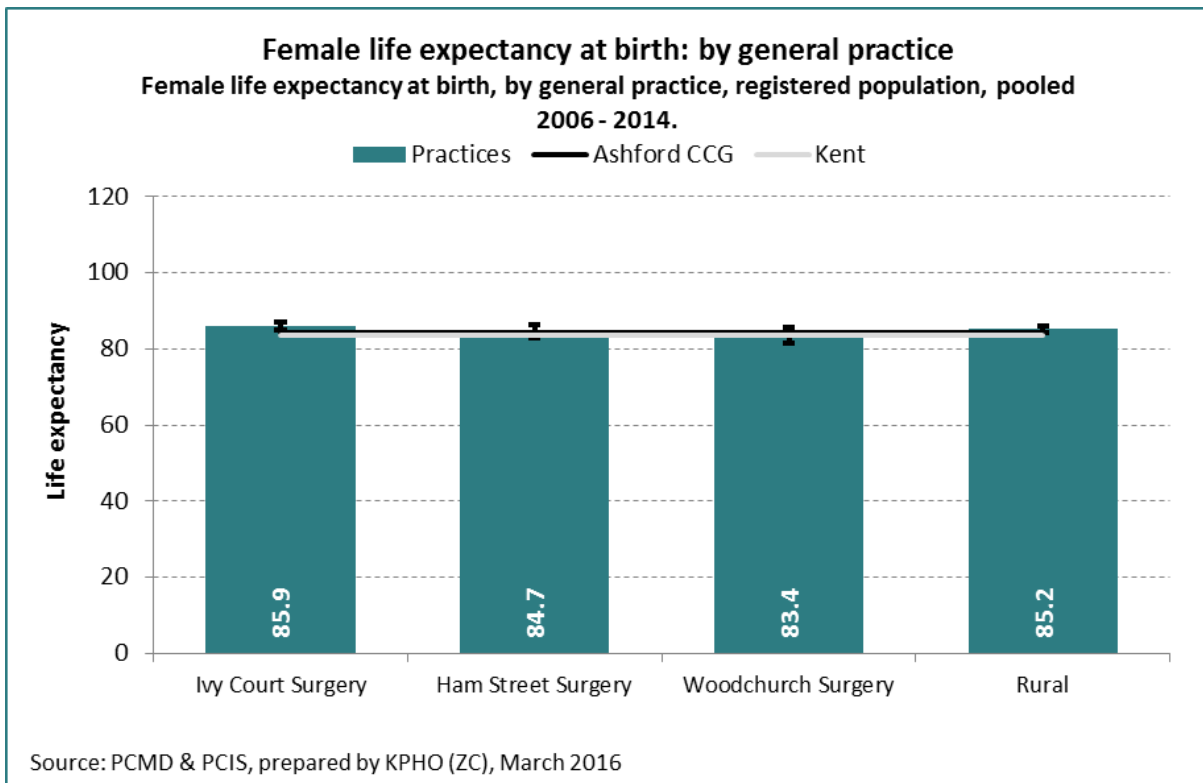
3.2 General fertility rate

In 2014, there were 17,305 live births in Kent and 1,474 (8.5%) of these were to Ashford residents. Data are sourced from the Public Health Birth File (PHBF); however, practice of registration information is not included in this dataset. Consequently, information is presented by ward and CCG of residence.

The general fertility rate GFR is defined as the number of live births per 1,000 women aged 15 to 44 years. This gives an indication of current fertility levels, but does not account for the different sizes of the population of age bearing women.
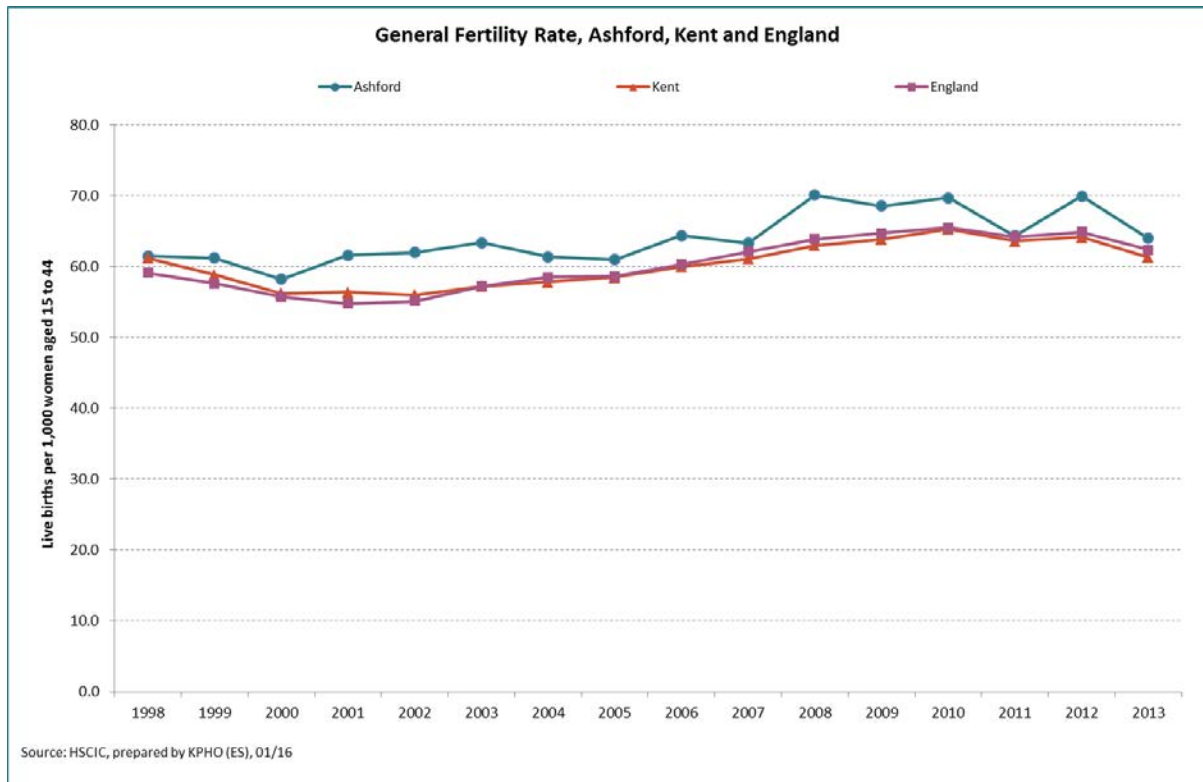
Since 1998, Ashford district has consistently had a higher GFR than both Kent and England; however, follows a similar pattern overall. GFR decreased between 1998 and 2000, before increasing to 2008. Since then, the rate has fluctuated but decreased notably in the past year.

General Fertility rate, 2010-2014 (pooled), Rural

Source: PHBF, ONS, prepared by KPHO (ES), 01/16
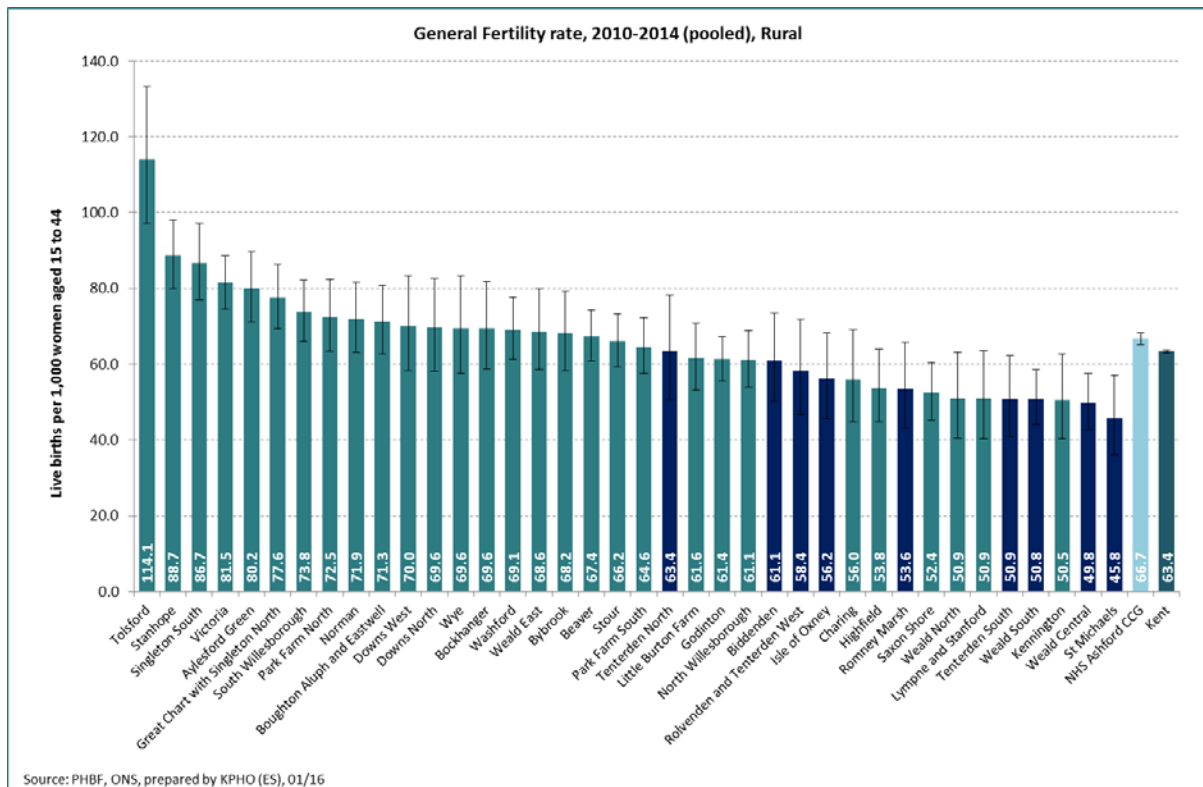
Ashford CCG (66.7) has a significantly higher GFR in comparison to Kent (63.4) for the 2010 to 2014 period. The wards within Rural clinical network all have lower GFR than Ashford CCG, the highest being Tenterden North (63.4). A number of wards have GFR which are significantly lower than both the CCG and Kent; Tenterden South, Weald South, Weald Central and St Michaels.

3.3   Low birth weight

Low birth weight is defined as the number of live births with stated birth weight below 2500g expressed as percentage of live births. In 2014, there were 979 low birth weight births in Kent, 72 of which were in Ashford CCG.

Babies born with a low birth weight (<2500g), three year aggregates

Source: ADBE, PHBF, prepared by KPHO (ES), 01/16
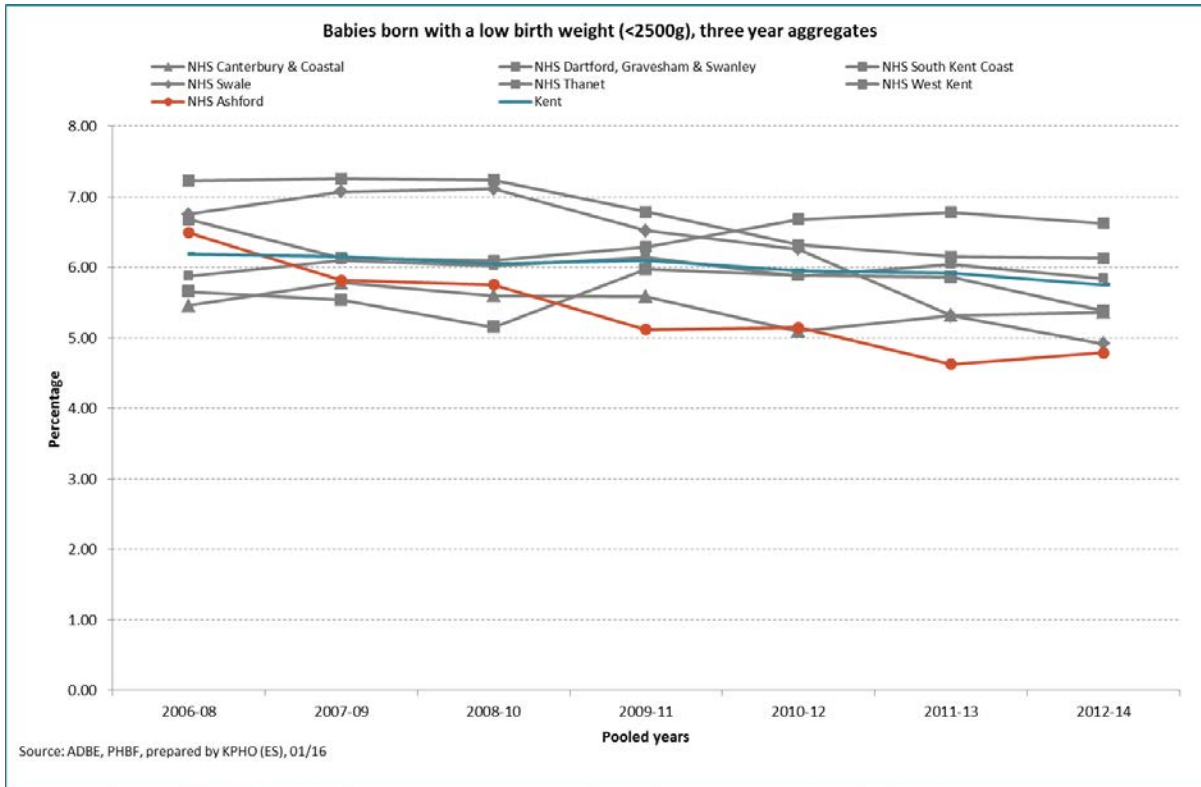
With the exception of 2006-08, the percentage of babies born with a low birth weight has been consistently lower in Ashford CCG than Kent. The CCG percentage decreased from 6.5% in 2006-08 to 4.6% in 2011-13; however has increased marginally to 4.8% in 2012-14. The annual rate of decrease in Ashford CCG is 0.3%, a faster rate of change than Kent (-0.1%); however this difference is not significant.

Babies born with a low birth weight (<2500g), 2012-14 (pooled)

Source: PHBF, prepared by KPHO (ES), 01/16
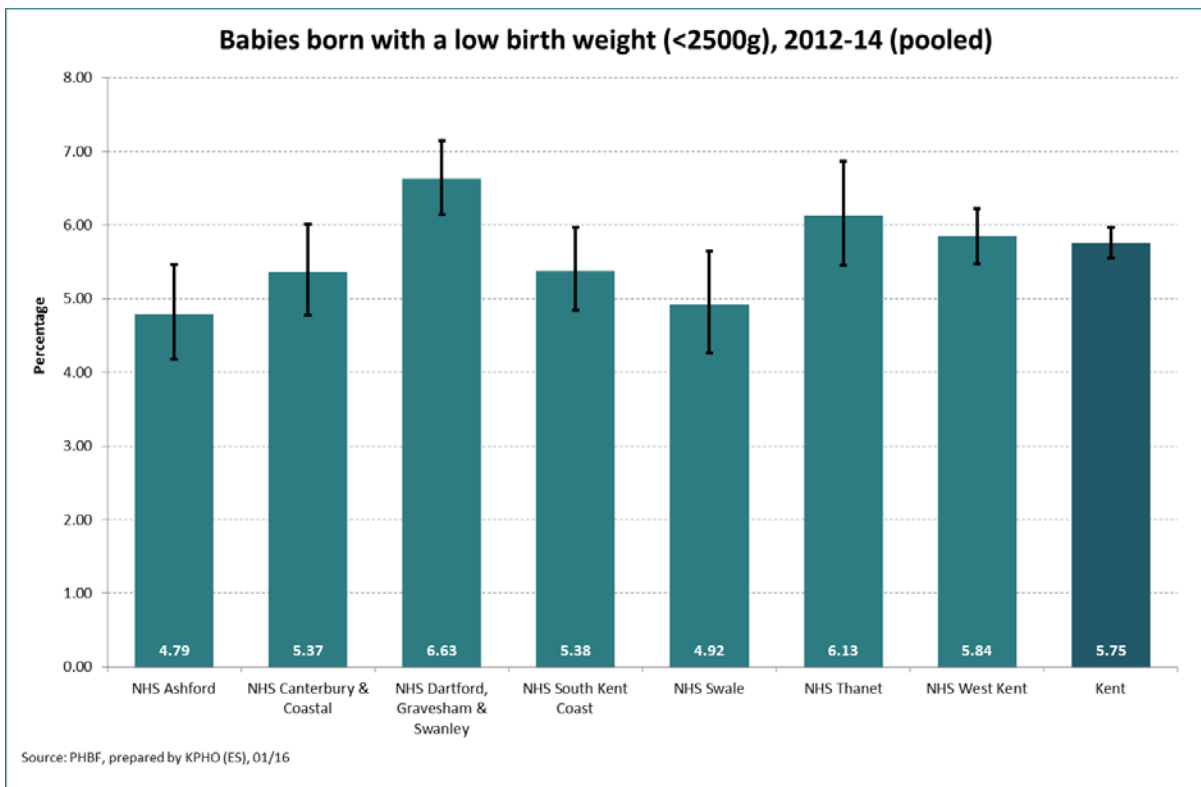
In 2012-14, Ashford CCG (4.79%) had the lowest percentage of low birth weight babies born
of all the Kent CCGs; significantly lower than the Kent percentage (5.85%).
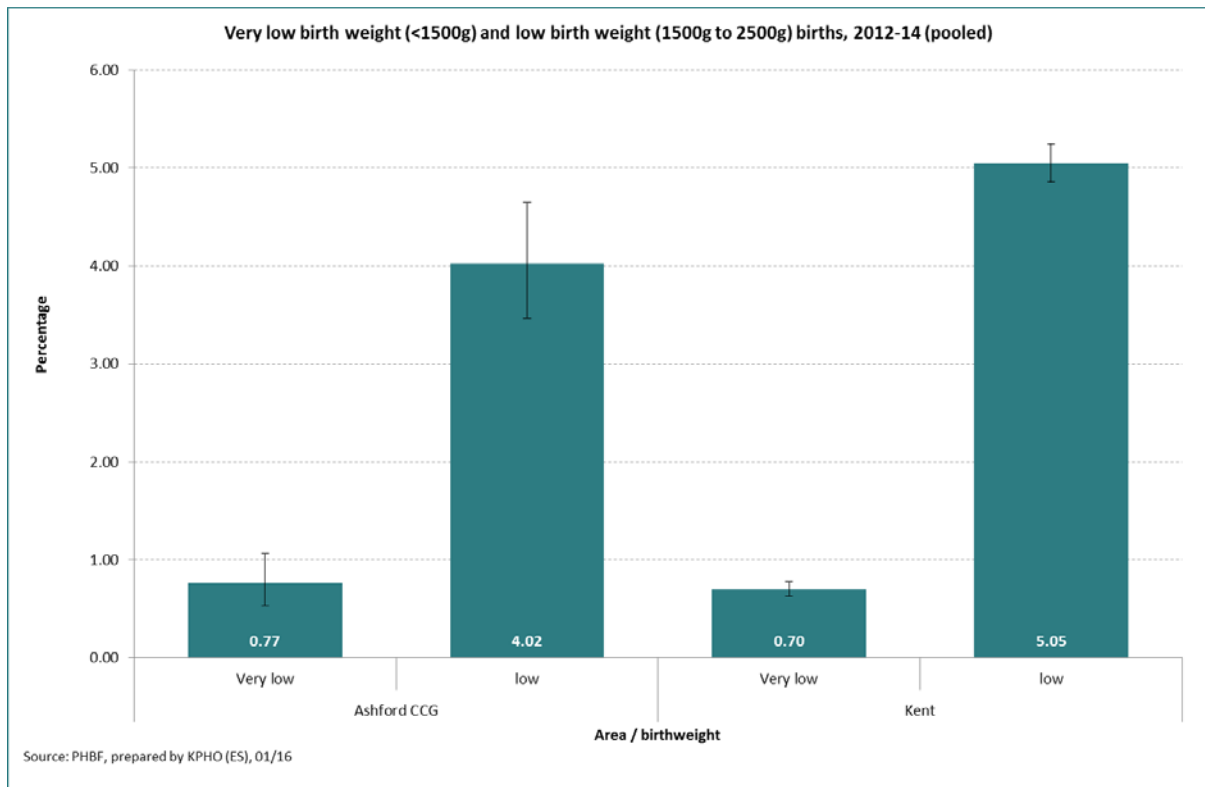
Ashford CCG has a significantly lower percentage (4.02%) of babies with a birth weight
between 1500g and 2500g than Kent, at 4.02% and 5.05% respectively. There is little
difference in the percentage of babies born weighing less than 1500g.

At a ward level, data have been pooled for five years due to small number of births with a
weight of below 2500g.

Babies born with a low birth weight (<2500g), 2010-14 (pooled), Rural

Source: PHBF, prepared by KPHO (ES), 01/16
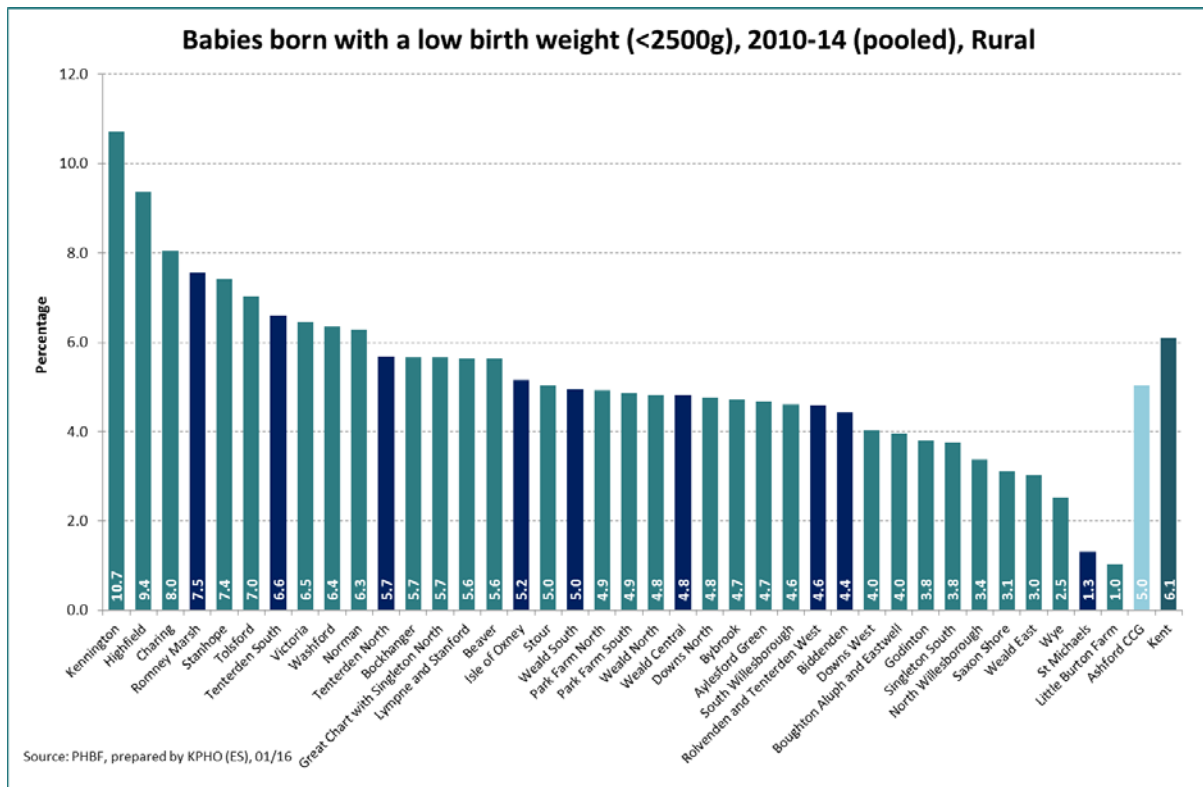
Based on 2010-2014 pooled data, Ashford CCG (5.0%, 95% CI; 4.5% to 5.6%) has a significantly lower proportion of low birth weight babies in comparison with Kent (6.1%; 5.9% to 6.2%). Within the network, the percentage of births with a low birth weight range from 1.3% in St Michael's ward to 7.5% in Romney Marsh; however none of the wards have significantly different percentages to either Ashford CCG or Kent.

3.4   Infant feeding

The following chart shows coverage and breastfeeding prevalence, which is recorded at the 6-8 week check. Coverage levels of 95% and greater have been recommended for the accurate assessment of breastfeeding prevalence. Data is currently only available at a GP practice level for early 2015/16.

Coverage rates below the recommended levels suggest that the prevalence indicators are less reliable and mask the true population prevalence with regard to breastfeeding continuation. Prevalence of breastfeeding is defined as the number of babies with a record of being either fully or partially breastfed at their 6 to 8 week check as a percentage of the number of infants due to 6 to 8 week check.

Breastfeeding continuation (6 to 8 weeks), quarter 1 2015/16

Network	Practice Code	Practice name	Coverage (%)	Prevalence (%)
Rural	G82053	Woodchurch Surgery	33.3	33.3
Rural	G82114	Ivy Court Surgery	50.0	28.1
Rural	G82186	Ham Street Surgery	64.3	28.6
Rural			**53.1**	**28.6**
Ashford CCG			**59.7**	**26.2**
Kent			**70.7**	**33.5**

Source: Child Health Information System

Whilst the table above details the prevalence of breastfeeding at the 6-8 week check, it should be noted that none of the practices achieve a coverage of greater than 95%. As a clinical network, Rural (53.1%) has a lower coverage than Ashford CCG (59.7%), which in turn is lower than Kent (70.7%). Whilst the prevalence of breastfeeding at 6 to 8 weeks is lower in Ashford (26.2%) than Kent (33.5%), Rural has a slightly higher prevalence than the CCG, at 28.6%.

3.5   Immunisations

The following charts show uptake of immunisations at 1, 2 and 5 years of age. Vaccine uptake gives an indication of the protection for the population against vaccine preventable disease.

The following key has been used to highlight vaccine coverage:

Less than 90%
Between 90 - 95%
More than 95%

Uptake (%) for children up to 12 months

Practice	12 month cohort		
	DTaP.IPV.Hib	MenC	PCV
Woodchurch Surgery, (G82053)	100.0	100.0	100.0
Ivy Court Surgery, (G82114)	86.4	93.2	84.7
Ham Street Surgery, (G82186)	93.8	96.9	93.8
Rural	**90.2**	**95.1**	**89.2**
Ashford CCG	**87.8**	**94.5**	**90.0**
Kent	**88.3**	**93.1**	**89.1**

Source: CHIS

Uptake (%) for children up to 24 months

Practice	24 month cohort				
	DTaP.IPV.Hib	MMR	MenC.Infant	Hib.MenC.Booster	PCV.Booster
Woodchurch Surgery, (G82053)	100.0	100.0	100.0	100.0	60.0
Ivy Court Surgery, (G82114)	84.6	92.3	87.2	84.6	56.4
Ham Street Surgery, (G82186)	93.9	87.9	93.9	87.9	36.4
Rural	**90.8**	**92.0**	**92.0**	**88.5**	**49.4**
Ashford CCG	**94.5**	**92.9**	**95.7**	**92.4**	**63.4**
Kent	**90.2**	**90.7**	**93.7**	**90.2**	**48.4**

Source: CHIS

Uptake (%) for children up to 5 years

Practice	5 year cohort									
	DT.Pol.Primary	DTaP.IPV.Booster	Pertussis.Primary	Hib.Infant	MenC.Infant	Hib.MenC.Booster	MMR.1st.dose	MMR.2nd.dose	PCV.Infant	PCV.Booster
Woodchurch Surgery, (G82053)	90.9	90.9	90.9	90.9	90.9	90.9	90.9	90.9	90.9	90.9
Ivy Court Surgery, (G82114)	95.1	88.5	95.1	95.1	95.1	90.2	93.4	88.5	93.4	91.8
Ham Street Surgery, (G82186)	97.8	91.3	97.8	97.8	100.0	97.8	97.8	89.1	97.8	95.7
Rural	**95.8**	**89.8**	**95.8**	**95.8**	**96.6**	**93.2**	**94.9**	**89.0**	**94.9**	**93.2**
Ashford CCG	**95.2**	**86.7**	**95.5**	**95.5**	**95.5**	**93.5**	**94.6**	**88.5**	**94.7**	**91.0**
Kent	**95.2**	**85.8**	**95.3**	**95.3**	**94.5**	**92.6**	**94.6**	**85.9**	**94.2**	**90.2**

Source: CHIS

Woodchurch Surgery has high uptake of immunisations, with the exception of 5 year olds; however, has relatively small cohorts of children. As a clinical network, Rural has uptake below then 90% threshold for PCV (12 month), Hib.MenC.Booster and PCV.Booster (24 months), and DTaP.IPV.Booster and MMR.2nd.dose (5 years).

3.6   Infant mortality

The following indicators and definitions have been used:

Indicator	Definition
Infant mortality rate	Number of deaths at ages under 1 year, per 1,000 live births.
Perinatal mortality rate	Number of stillbirths plus number of deaths at ages under 7 days, per 1,000 live births and stillbirths.
Early neonatal mortality rate	Number of deaths at ages under 7 days, per 1,000 live births.
Neonatal mortality rate	Number of deaths at ages under 28 days, per 1,000 live births.
Post neonatal mortality	Number of deaths at ages 28 days and over, but under 1 year, per 1,000 live births.
Stillbirth rate	Number of stillbirths per 1,000 live births and stillbirths.

The following chart shows the infant mortality statistics for the pooled period 2006-2014.
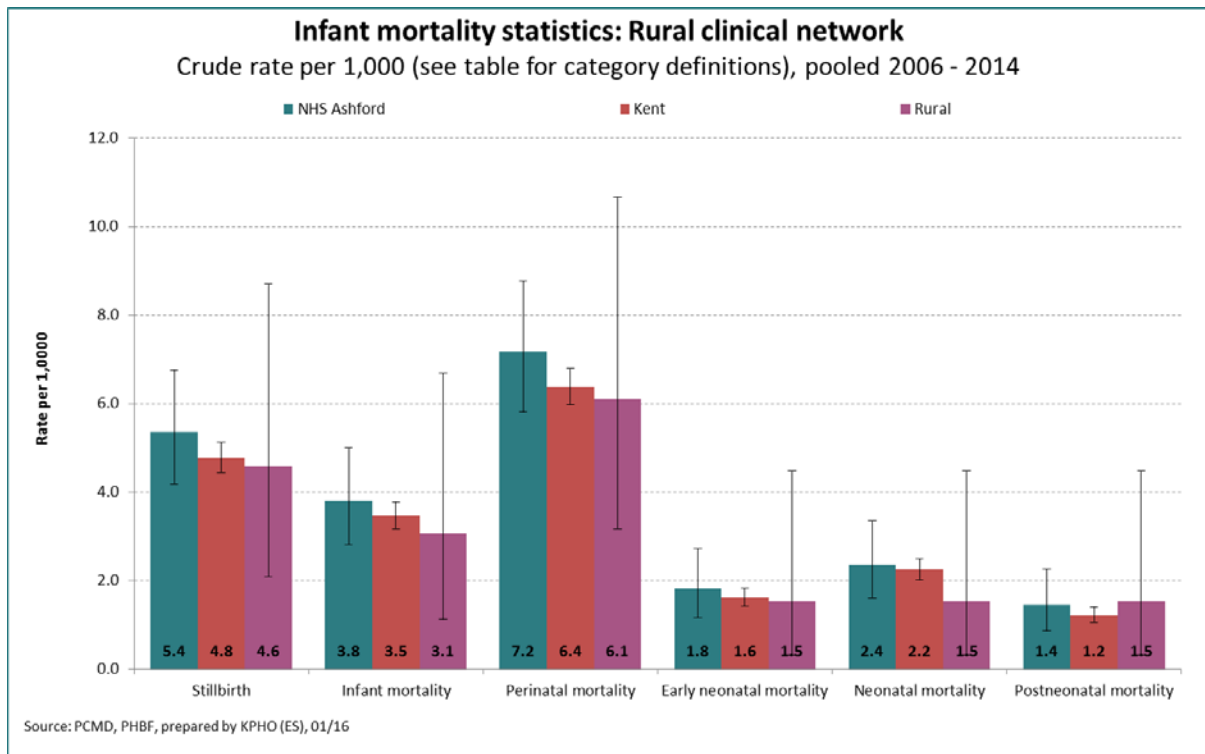
Infant mortality statistics: Rural clinical network
Crude rate per 1,000 (see table for category definitions), pooled 2006 - 2014

Source: PCMD, PHBF, prepared by KPHO (ES), 01/16

Rural clinical network has a lower mortality rate for all indicators with the exception of post neonatal mortality; however, none of the differences observed are significant.

| 4. Demographic overview

4.1 Practice population

4.1.1 Registered population

The total registered population was 24,686 persons within the Rural clinical network, within the first quarter of 2015/16. Overall, 51.6% of the population were female and 48.4% male within the Rural clinical network, similar to Ashford CCG (51.0% female and 49.0% male).

The below population pyramid details the population structure of the Rural clinical network, which has some differences in structure in comparison to Ashford CCG. Within the Rural clinical network, there were over 10,000 persons aged 55 years and over, contributing 42.0% to the total population. Also, a lower proportion of the population were aged under 40 years.

Population pyramid for registered population.
Registered population within Rural clinical network in comparison to Ashford CCG, Q1 2015/16.

Source: ONS, prepared by KPHO (ZC), March 2016
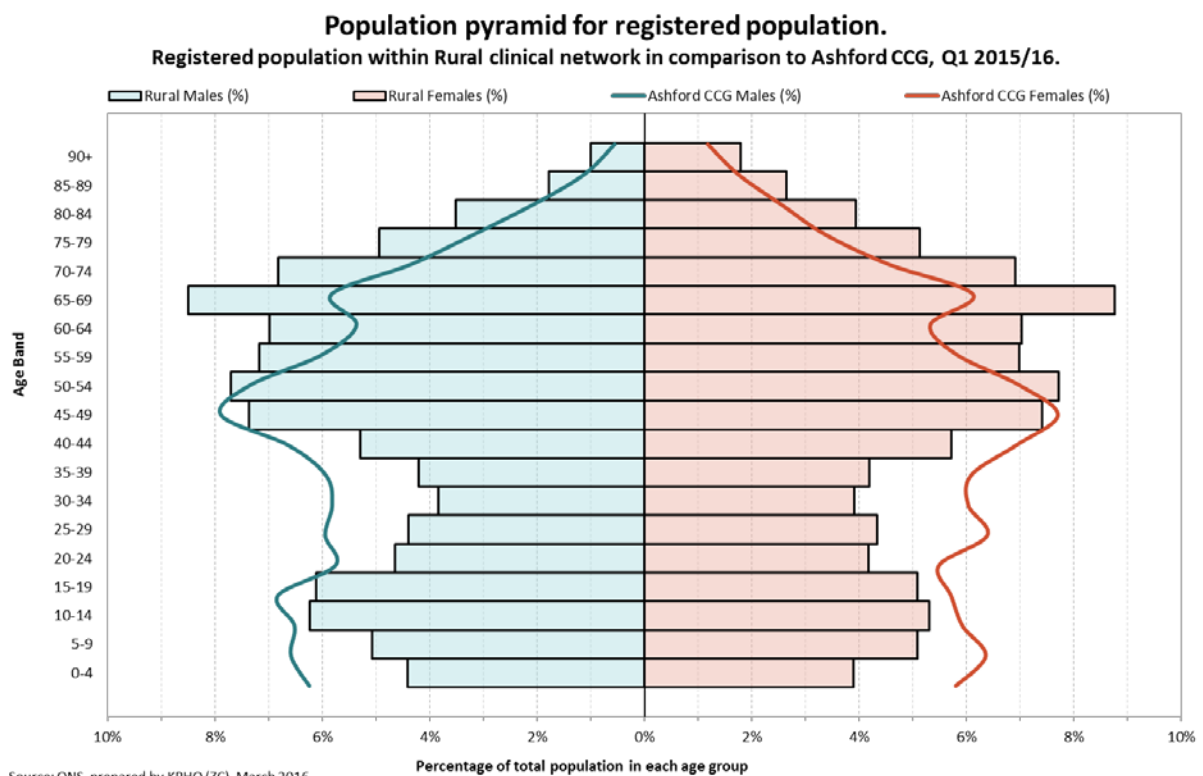
Table 3: Registered population in Rural clinical network, June 2015/16.

Age band	Males	Females	Persons
0-4	527	497	1,024
5-9	605	649	1,254
10-14	745	677	1,422
15-19	730	648	1,378
20-24	554	532	1,086
25-29	525	552	1,077
30-34	459	498	957
35-39	502	534	1,036
40-44	631	729	1,360
45-49	879	944	1,823
50-54	919	984	1,903
55-59	856	890	1,746
60-64	834	895	1,729
65-69	1,015	1,117	2,132
70-74	814	881	1,695
75-79	589	654	1,243
80-84	420	502	922
85-89	212	338	550
90+	120	229	349
Total	11,936	12,750	24,686

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4.2   Ethnicity

Ethnic group data was sourced from the Census, 2011, the percentage of the population belonging to minority ethnic groups was calculated. Ethnic minority groups include; Black, Asian, Mixed and Other ethnic categories. All of the wards within the Rural clinical network had lower proportions of ethnic minority groups in comparison to Ashford CCG.

Percentage of ethnic minority: by ward
Ethnic minority groups as a percentage of resident population, 2011

Legend
	1.40 - 2.07
	2.08 - 3.20
	3.21 - 6.60
	6.61 - 8.30
	8.31 - 12.11

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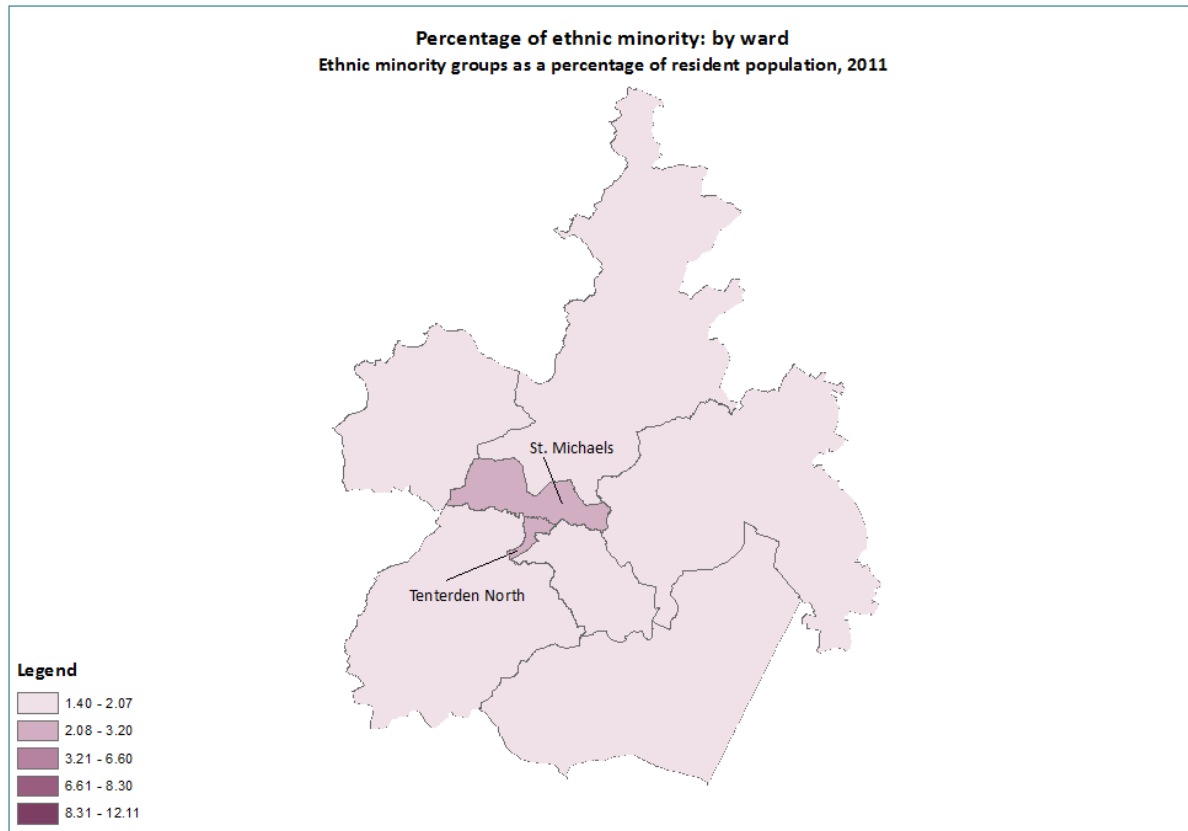
Table 4: Percentage of ethnic minority groups: by ward.

Ward	Ethnic minority group	Difference
Biddenden	1.9%	Lower
Isle of Oxney	1.6%	Lower
Rolvenden & Tenterden West	2.1%	Lower
St Michaels	4.6%	Lower
Tenterden North	2.2%	Lower
Tenterden South	1.6%	Lower
Weald Central	1.4%	Lower
Weald South	1.8%	Lower

| 5. Socio-economic profile

5.1 Deprivation

5.1.1 Index of Multiple Deprivation 2015

The English Indices of Deprivation 2015 use 38 separate indicators, organised across seven distinct domains of deprivation which can be combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2015 (IMD 2015). This is an overall measure of multiple deprivation experienced by people living in an area. Seven distinct domains have been identified in the English Indices of Deprivation; Income Deprivation, Employment Deprivation, Health Deprivation and Disability, Education, Skills and Training Deprivation, Barriers to Housing and services, Living Environment Deprivation and Crime.

The indices have been contructed by Oxford Consultants for Social Inclusion (OCSI); estimates for GP practices have been calculated by the Department of Primary Care and Public Health Sciences, King's College London.

Indices of multiple deprivation 2015, by practice

Source: DCLG, PHE, prepared by KPHO (ES), 01/16
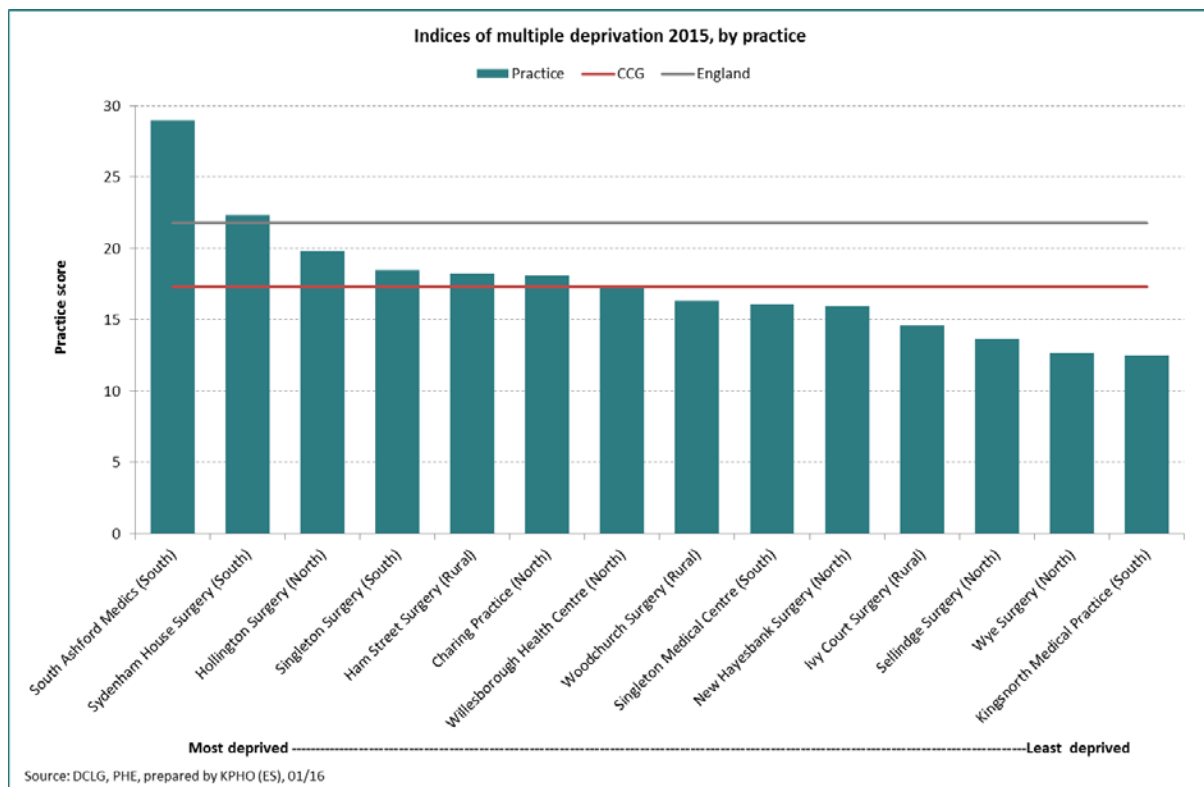
None of the practices in Rural Clinical Network have a score above the England average, and only Ham Street Surgery has a score above Ashford CCG.

5.1.2 Income Deprivation Affecting Children Index 2015

The Income Deprivation Affecting Children Index (IDACI) is derived from the Income domain within the overall Indices of Deprivation and is used as a 'child poverty' measure. IDACI is defined as the proportion of children aged 0–15 years living in income deprived households

as a proportion of all children aged 0–15 years. Practice level IDACI estimates have been calculated by the Department of Primary Care and Public Health Sciences, King's College London by applying LSOA level deprivation data proportionally to practice populations.

Income of deprivation affecting children 2015, by practice
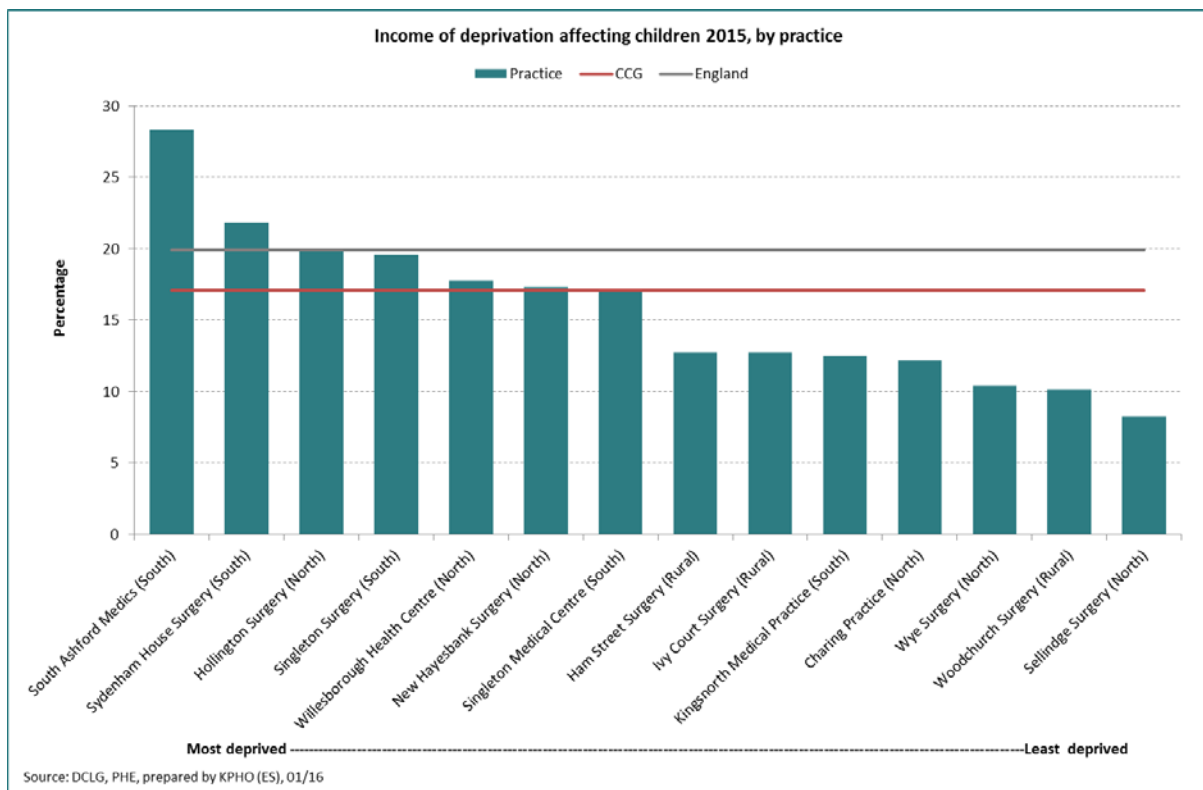
Ashford CCG has a lower proportion of children living in income deprived households (17.1%) in comparison to Kent (19.9%). The practices in Rural clinical network have markedly lower proportions of children living in income deprived households, the highest being Ham Street Surgery, with 12.7%.

5.1.3   Income Deprivation Affecting Older People Index 2015

The Income Deprivation Affecting Older People Index (IDAOPI) is also derived from the Income domain within the overall Indices of Deprivation and is used as an 'older people poverty' measure. IDAOPI is defined as the proportion of adults aged 60 years or over living in pension credit (guarantee) households as a proportion of all those aged 60 years or over. Practice level IDACI estimates have been calculated by the Department of Primary Care and Public Health Sciences, King's College London by applying LSOA level deprivation data proportionally to practice populations.

Income deprivation affecting older people 2015, by practice

Source: DCLG, PHE, prepared by KPHO (ES), 01/16
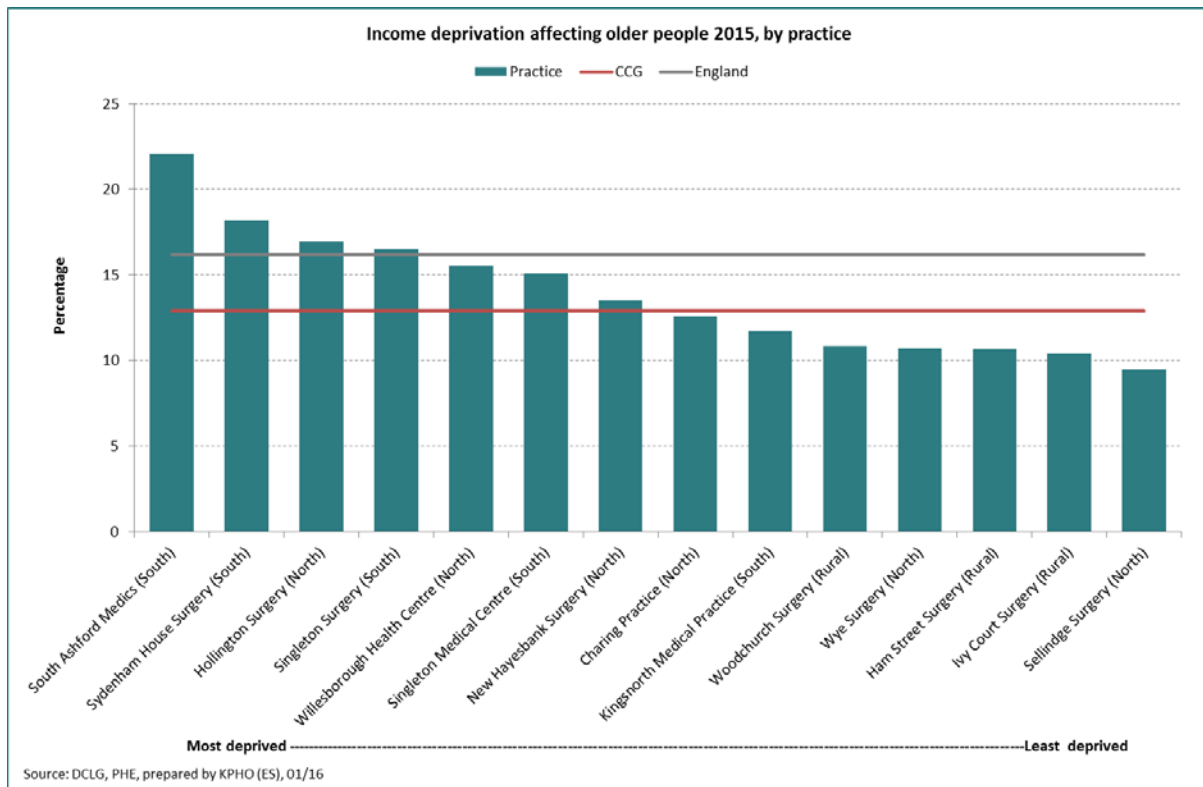
Ashford CCG has a lower proportion of older people living in pension credit (guarantee) households (12.9%) in comparison to Kent (16.2%). The three practices within Rural Clinical Network have low percentages of older people living in pension credit (guarantee) households, the highest being in Woodchurch Surgery at 10.9%.

| 6. Lifestyle

6.1 Alcohol

6.1.1 Modelled Binge Drinking Estimates

Binge drinking estimates t a small geographic level are produced for the Association of Public Health Observatories (2006/08) and detail the percentage of adults who consume at least twice the daily recommended amount of alcohol in a single session (that is, eight or more units for men and six or more units for women).
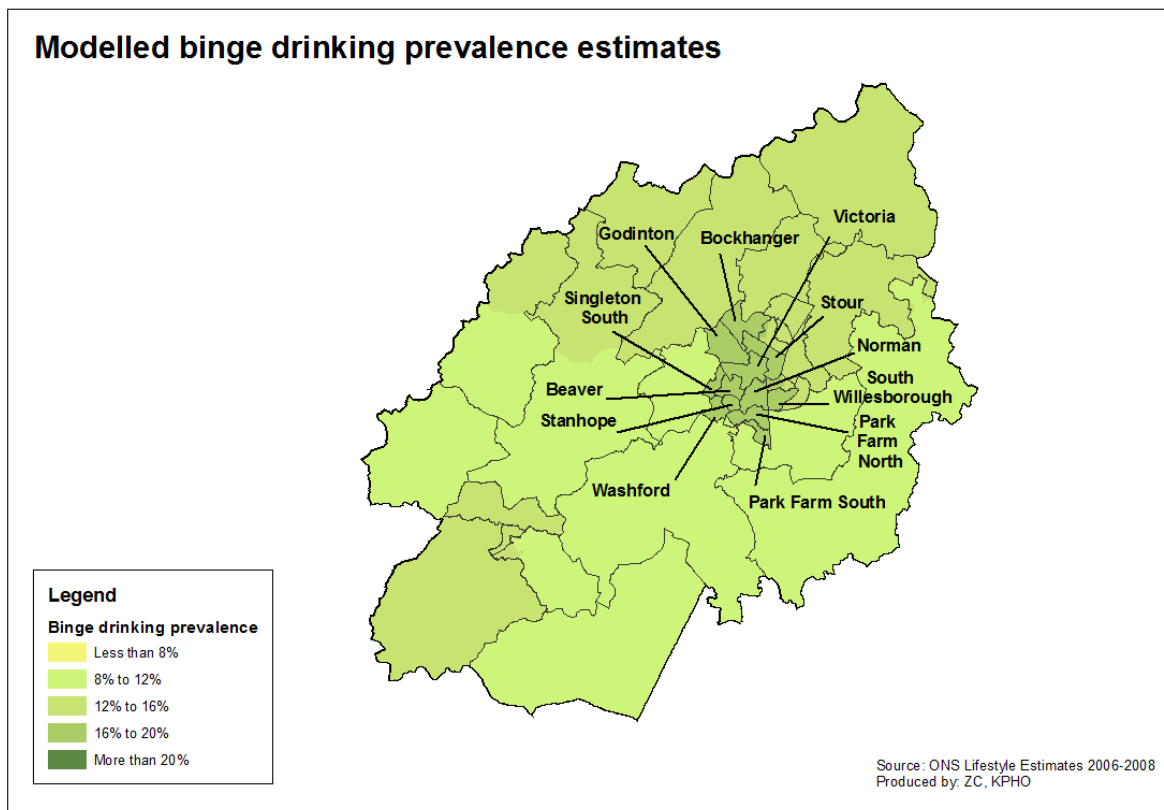
Binge drinking prevalence is greatest (16% to 20%) in the more populous wards towards the centre of Ashford. The rates in the rural northern areas are very slightly higher than those in the rural south of Ashford (with the exception of Tenterden).

More widely, the rate of admissions to hospital for alcohol related conditions is used as an alternative measure of alcohol consumption. The admission rate across England is 645 per 100,000, this compares to 525 for the south east region, 551 for Kent and 572 for Ashford.

6.2   Obesity

6.2.1   Modelled Adult Obesity Estimates

Adult obesity rates for small area geography are modelled from national surveys and produced by the Office for National Statistics.
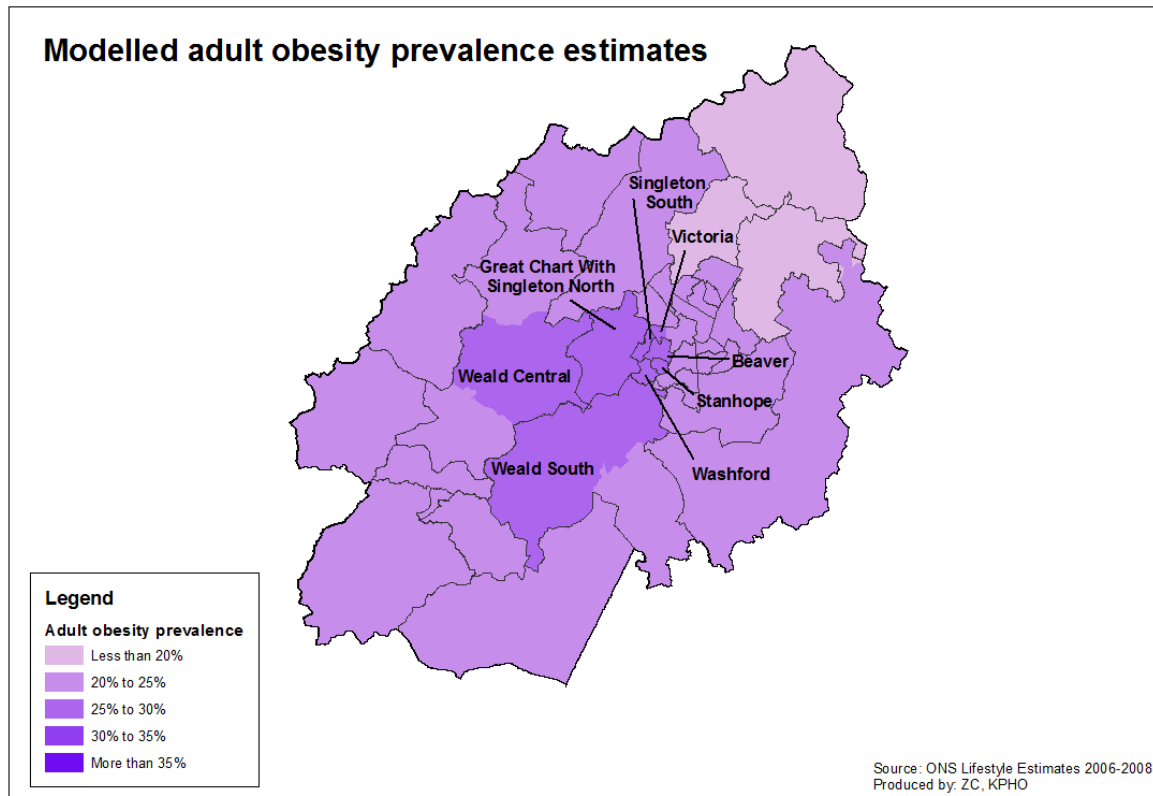
The higher prevalence of adult obesity is found in the south eastern areas of Ashford town. The lowest prevalence is located toward the north western electoral wards of the district.

The Public Health Outcomes Framework records excess weight in adults, that is the combined prevalence of obese and overweight adults. Across England the excess weight in adults prevalence is 64.6%, for the south east region it is 63.4%, Kent 65.1% and the figure for Ashford district is 67.5%.

6.3   Smoking

6.3.1   Modelled Adult Obesity Estimates

Modelled smoking prevalence figures, at a small area level, were produced by the Office for National Statistics.
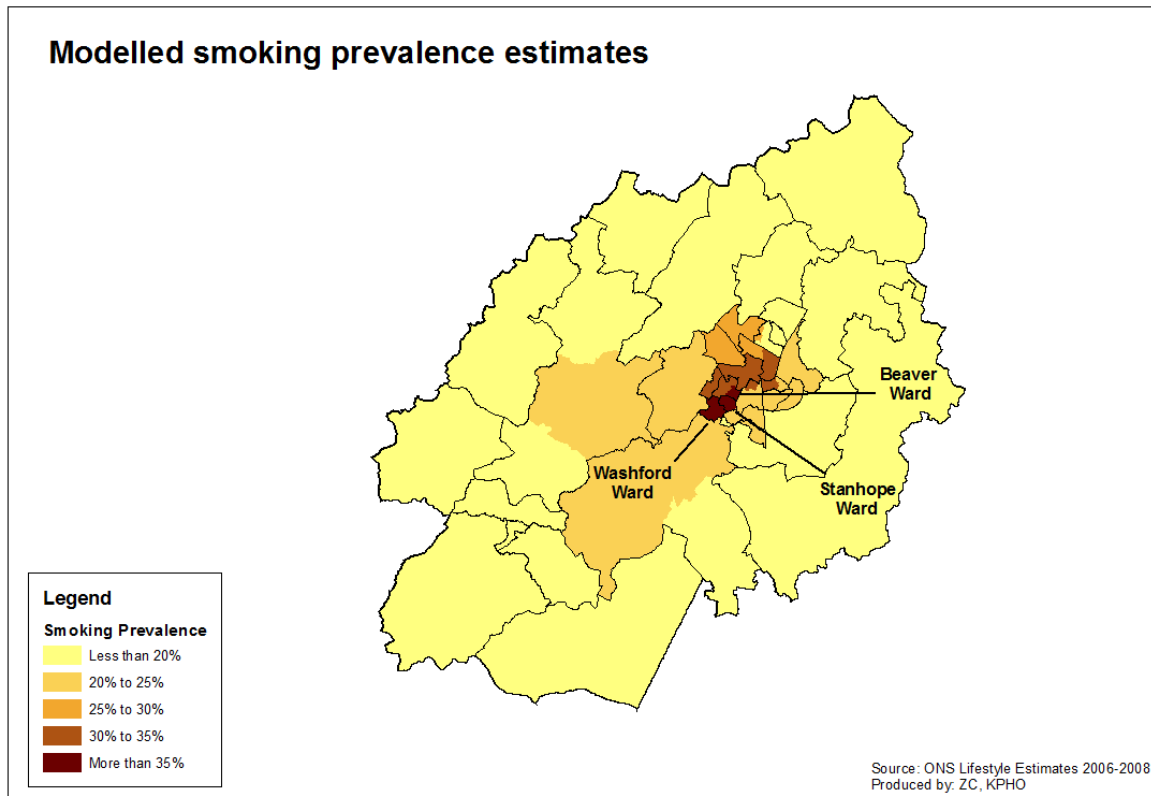
Smoking prevalence in Ashford is greatest in Washford, Stanhope and Beaver wards, other central town centre wards also have high prevalence's of adult smoking. The rural areas of the district have prevalence levels that are almost half those of the urban central wards.

The smoking prevalence's given above are for small areas and relate to 2006-2008 – smoking prevalence figures are no longer constructed for small areas and so these should be viewed as an indicator of where the high prevalence is likely to be.

The Public Health Outcomes Framework also lists smoking prevalence at district, county and regional levels. The prevalence across England is 18% although this rises to 28% in the routine and manual population. For the south east region prevalence is 16.6% rising to 28% in routine and manual, for Kent it is 19.1% and 32.7% respectively. Ashford shows levels of smoking prevalence that are much higher – 26.4% across the adult population and a massive 42.1% in routine and manual workers.

| 7. Mental Health

7.1   Contact with services

Mental health contact rate data has been provided by Kent and Medway NHS and social care partnership for 2014. The following contact rates are number of individuals in contact with services rather than total number of contacts.

7.1.1   Mental health contacts: age 15 to 64
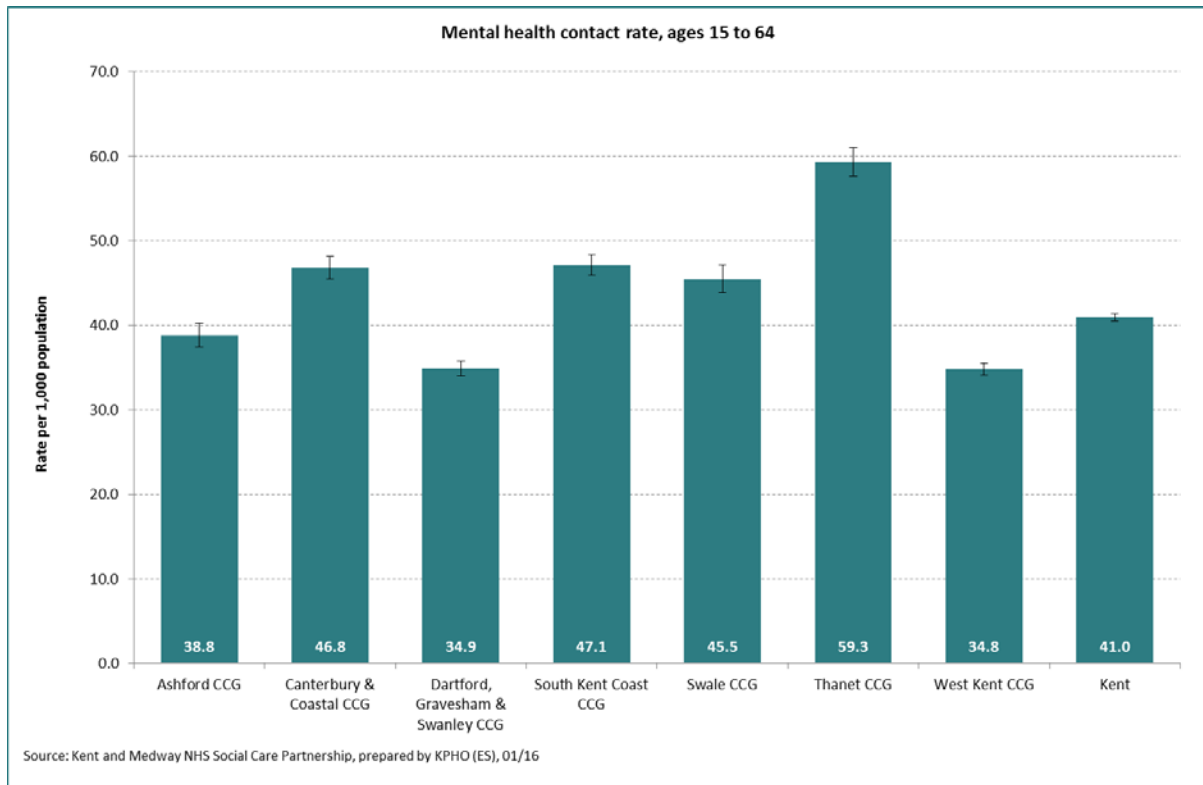
For people aged 15 to 64, the mental health contact rate ranges from 34.8 per 1,000 population in West Kent CCG to 59.3 in Thanet CCG. Ashford CCG (38.8) is significantly lower than the Kent rate (41.0).
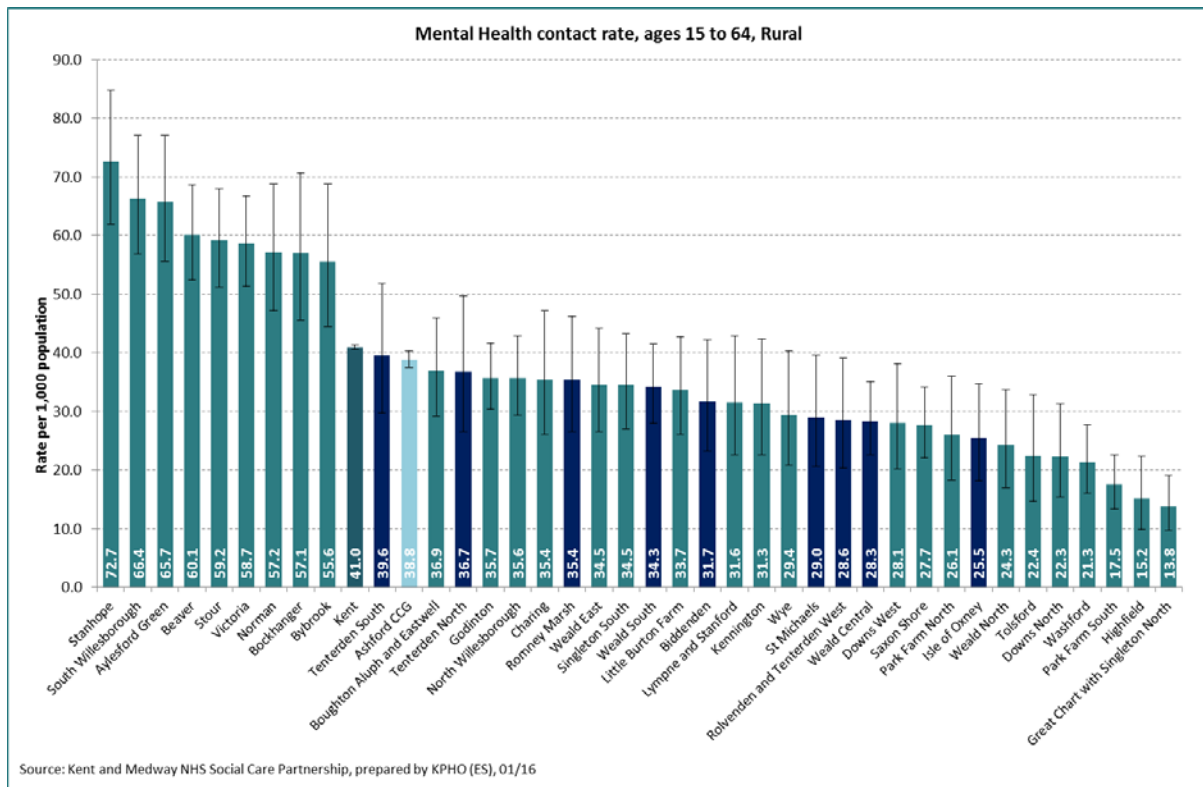
Ashford CCG clinical network profile, February 2016

Mental Health contact rate, ages 15 to 64, Rural

Source: Kent and Medway NHS Social Care Partnership, prepared by KPHO (ES), 01/16

Within Rural clinical network, the mental health contact rate for people aged 15 to 64 ranges from 25.5 in Isle of Oxney ward to 39.6 in Tenterden South. Weald Central and the Isle of Oxney have significantly lower rates than Kent and the CCG.

7.1.2 Mental health contacts: age 65 and above

Mental health contact rate, ages 65 and above

Source: Kent and Medway NHS Social Care Partnership, prepared by KPHO (ES), 01/16
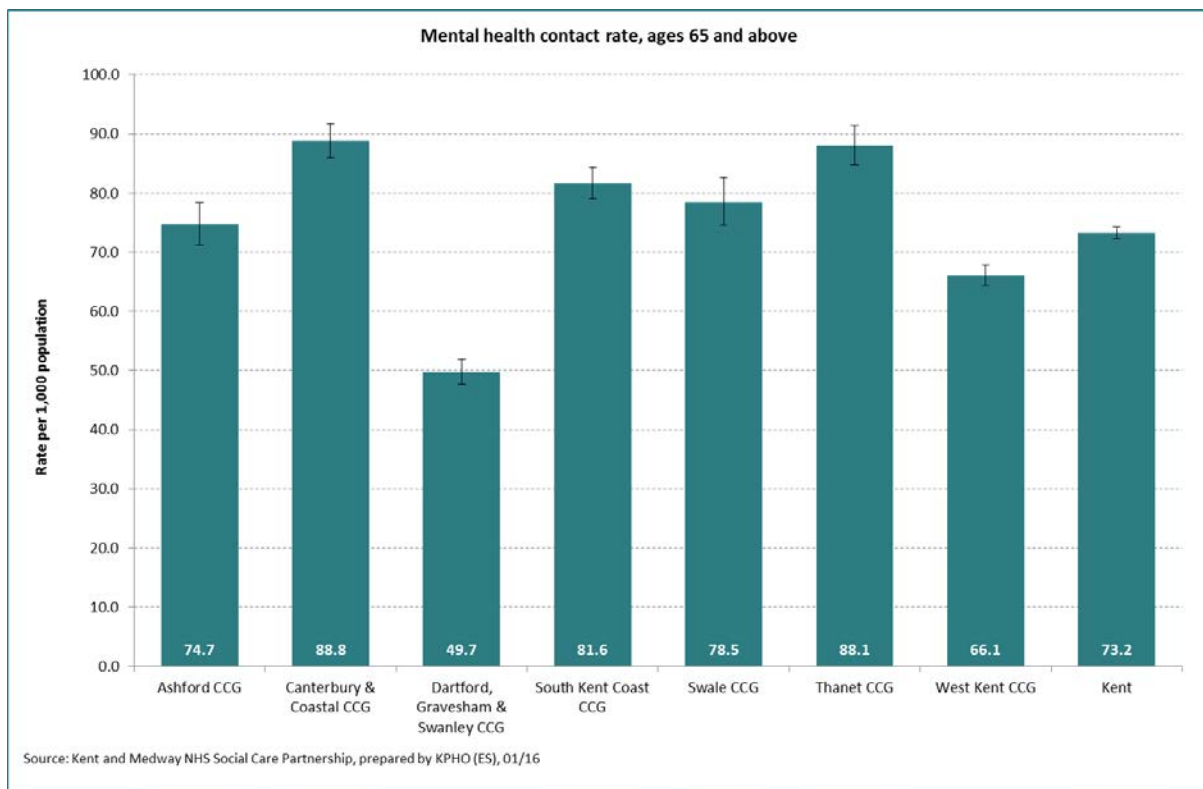
Across Kent, the contact rate for mental health services ranges from 49.7 contacts per 1,000 population aged 65 and above in Dartford, Gravesham and Swanley CCG to 88.8 in Canterbury and Coastal CCG. The Ashford CCG rate (74.7) is not significantly different to the Kent rate (73.2).
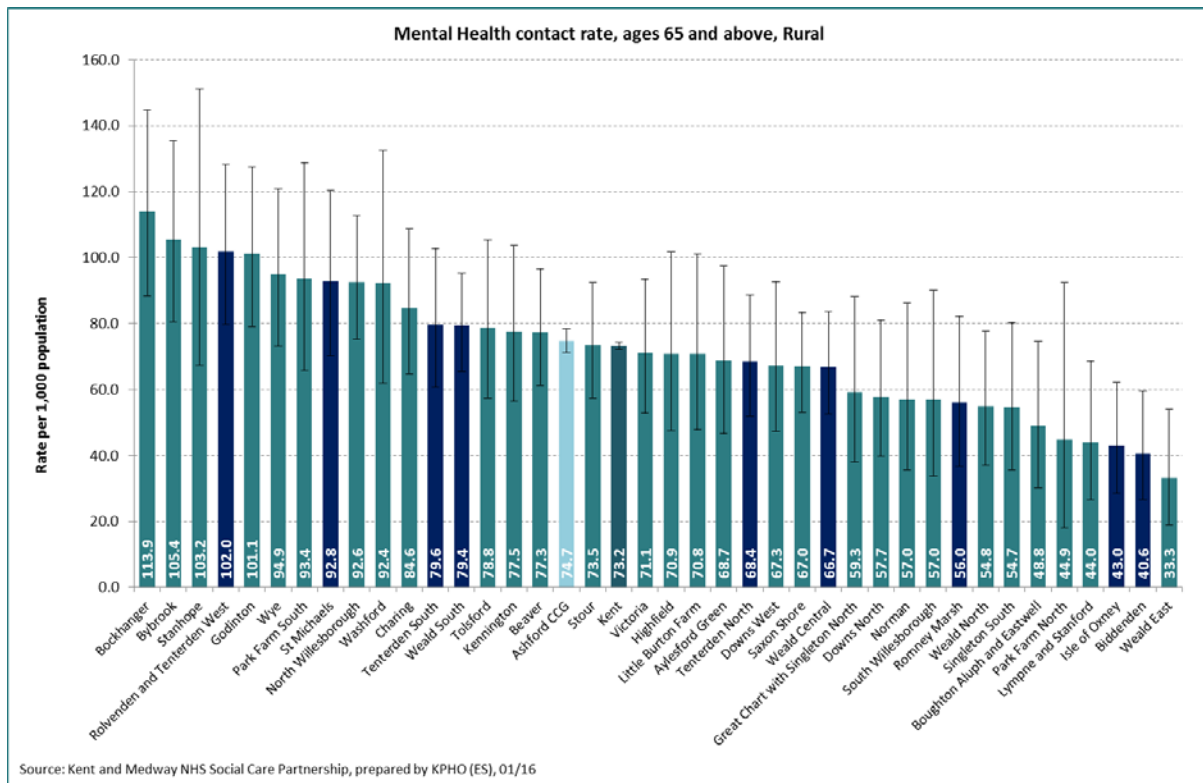
Mental Health contact rate, ages 65 and above, Rural

Source: Kent and Medway NHS Social Care Partnership, prepared by KPHO (ES), 01/16

In Rural clinical network, the 65 and above mental health contact rate ranges from 40.6 per 1,000 population in Biddenden to 102.0 in Rolvenden and Tenterden West. Rolvenden and Tenterden West ward has a significantly higher rate than Ashford CCG and Kent, whilst the Isle of Oxney and Biddenden have significantly lower rates.

Ashford CCG clinical network profile, February 2016

| 8. Quality outcomes framework

8.1 Recorded prevalence

Spine charts have been produced to compare the general practice recorded prevalence of long term conditions with the Ashford CCG recorded prevalence in 2014/15.

The Quality outcomes framework (QOF) uses an extract of practice list sizes as of 1st January 2015 and disease registers as at 31st March 2015.

Recorded prevalence for most of long term conditions uses the total practice population. However, this differs for the following:

- Obesity – 16 years and over practice population.
- Diabetes– 17 years and over practice population.
- Chronic kidney disease – 18 years and over practice population
- Epilepsy - 18 years and over practice population

The practice population list sizes will be referred to below.

Key:

●	Significantly much higher than CCG average
●	Significantly higher than CCGaverage
●	Not significantly different from CCG average
●	Significantly low er than CCG average
●	Significantly much low er than CCG average
○	No significance can be calculated

Limitations

A limitation of the QOF recorded prevalence is that analysis cannot differentiate between true prevalence and the effectiveness of case finding strategies between practices.

The projected recorded prevalence has not been adjusted for any other factors known to influence the risk of long term conditions, such as changes in deprivation and in the demographic patterns of at risk population groups (such as, age). It is likely therefore, that the prevalence projections shown in this section are likely to be conservative estimates.

8.1.1 Rural clinical network

For the purposes of the 2014/2015 QOF data, Ashford Rural network had the following population:

Age	Ashford Rural
All age	24,812
16+	20,818
17+	20,529
18+	20,237

In 2014/15 Ashford Rural network had significantly higher prevalence of the following conditions in comparison to Ashford CCG:

- Atrial fibrillation
- Asthma
- Cancer
- Coronary heart disease
- Dementia
- Diabetes
- Hypertension
- Learning disability
- Obesity

In 2014/15 Ashford rural network recorded no conditions with a prevalence significantly lower than the average rate for Ashford CCG.

Indicator	AR - Ashford Rural Network		CCG					Kent
	Register count	Prevalence	Prevalence	CCG lowest		CCG		CCG highest	prevalence
Atrial fibrillation	845	3.4	2.3	0.7			3.7	1.9
Asthma	1513	6.1	5.8	4.0			7.4	5.6
Cancer	866	3.5	2.4	0.8			4.1	2.5
Coronary heart disease	1021	4.1	3.1	1.7			5.5	3.1
Chronic kidney disease	1026	5.1	5.1	3.0			7.7	5.1
COPD	469	1.9	1.7	1.1			2.4	1.9
Dementia	264	1.1	0.7	0.1			2.1	0.8
Diabetes	1363	6.6	6.2	4.9			7.4	6.2
Depression	1659	8.2	8.6	3.8			12.9	7.3
Epilepsy	149	0.7	0.8	0.4			1.2	0.8
Heart Failure	168	0.7	0.6	0.3			0.9	0.6
Hypertension	4455	18.0	14.3	8.4			18.3	14.6
Learning disability	156	0.6	0.4	0.2			1.2	0.4
Mental health	140	0.6	0.7	0.4			1.4	0.8
Obesity	2096	8.4	7.5	3.9			10.8	7.2
Palliative Care	40	0.2	0.1	0.0			0.5	0.2
Stroke	631	2.5	1.8	0.9			2.9	1.8

8.1.2 G2053 Woodchurch Surgery

For the purposes of the 2014/2015 QOF data, Woodchurch Surgery had the following population:

Age	G82053
All age	3,561
16+	3,018
17+	2,976
18+	2,936

In 2014/15 Woodchurch Surgery had significantly higher prevalence of the following conditions in comparison to Ashford CCG:

- Atrial fibrillation
- Asthma

Ashford CCG clinical network profile, February 2016

- Cancer
- Coronary heart disease
- Chronic kidney disease
- COPD
- Dementia
- Heart failure
- Hypertension
- Learning disability
- Obesity
- Palliative Care

In 2014/15 Woodchurch Surgery recorded no conditions with a prevalence significantly lower than the average rate for Ashford CCG.

| Indicator | G82053 - Woodchurch Surgery | | CCG | | | | Kent prevalence |
	Register count	Prevalence	Prevalence	CCG lowest	CCG	CCG highest	
Atrial fibrillation	130	3.7	2.3	0.7		3.7	1.9
Asthma	265	7.4	5.8	4.0		7.4	5.6
Cancer	146	4.1	2.4	0.8		4.1	2.5
Coronary Heart Disease	196	5.5	3.1	1.7		5.5	3.1
Chronic Kidney Disease	209	7.1	5.1	3.0		7.7	5.1
COPD	82	2.3	1.7	1.1		2.4	1.9
Dementia	76	2.1	0.7	0.1		2.1	0.8
Diabetes	206	6.9	6.2	4.9		7.4	6.2
Depression	208	7.1	8.6	3.8		12.9	7.3
Epilepsy	27	0.9	0.8	0.4		1.2	0.8
Heart Failure	33	0.9	0.6	0.3		0.9	0.6
Hypertension	636	17.9	14.3	8.4		18.3	14.6
Learning disability	41	1.2	0.4	0.2		1.2	0.4
Mental health	16	0.4	0.7	0.4		1.4	0.8
Obesity	314	8.8	7.5	3.9		10.8	7.2
Palliative Care	17	0.5	0.1	0.0		0.5	0.2
Stroke	92	2.6	1.8	0.9		2.9	1.8

8.1.3 G82114 Ivy Court Surgery

For the purposes of the 2014/2015 QOF data, Ivy Court Surgery had the following population:

Age	G82114
All age	14,515
16+	12,244
17+	12,063
18+	11,870

In 2014/15 Ivy Court Surgery had significantly higher prevalence of the following conditions in comparison to Ashford CCG:

- Atrial fibrillation
- Cancer
- Coronary heart disease
- Dementia

- Diabetes
- Hypertension
- Obesity

In 2014/15 Ivy Court Surgery had significantly lower prevalence of the following conditions in comparison to Ashford CCG.

- Depression
- Palliative Care

Indicator	G82114 - Ivy Court Surgery		CCG					Kent
	Register count	Prevalence	Prevalence	CCG lowest	CCG		CCG highest	prevalence
AF	534	3.7	2.3	0.7			3.7	1.9
Asthma	854	5.9	5.8	4.0			7.4	5.6
Cancer	468	3.2	2.4	0.8			4.1	2.5
CHD	547	3.8	3.1	1.7			5.5	3.1
CKD	567	4.8	5.1	3.0			7.7	5.1
COPD	273	1.9	1.7	1.1			2.4	1.9
Dementia	156	1.1	0.7	0.1			2.1	0.8
Diabetes	812	6.7	6.2	4.9			7.4	6.2
Depression	808	6.8	8.6	3.8			12.9	7.3
Epilepsy	87	0.7	0.8	0.4			1.2	0.8
Heart Failure	89	0.6	0.6	0.3			0.9	0.6
Hypertension	2655	18.3	14.3	8.4			18.3	14.6
Learning disability	59	0.4	0.4	0.2			1.2	0.4
Mental health	94	0.6	0.7	0.4			1.4	0.8
Obesity	1273	8.8	7.5	3.9			10.8	7.2
Palliative Care	8	0.1	0.1	0.0			0.5	0.2
Stroke	417	2.9	1.8	0.9			2.9	1.8

8.1.4 G82186 Ham Street Surgery

For the purposes of the 2014/2015 QOF data, Ham Street Surgery had the following population:

Age	G82186
All age	6,736
16+	5,556
17+	5,489
18+	5,431

In 2014/15 Ham Street Surgery had significantly higher prevalence of the following conditions in comparison to Ashford CCG:

- Atrial fibrillation
- Cancer
- Coronary heart disease
- Depression
- Hypertension
- Learning disability
- Palliative Care

In 2014/15 Ham Street Surgery had significantly lower prevalence of the following conditions in comparison to Ashford CCG.

- Dementia
- Mental Health

Indicator	G82186 - Ham Street Surgery		CCG				Kent prevalence
	Register count	Prevalence	Prevalence	CCG lowest	CCG	CCG highest	prevalence
Atrial fibrillation	181	2.7	2.3	0.7		3.7	1.9
Asthma	394	5.8	5.8	4.0		7.4	5.6
Cancer	252	3.7	2.4	0.8		4.1	2.5
Coronary heart disease	278	4.1	3.1	1.7		5.5	3.1
Chronic kidney disease	250	4.6	5.1	3.0		7.7	5.1
COPD	114	1.7	1.7	1.1		2.4	1.9
Dementia	32	0.5	0.7	0.1		2.1	0.8
Diabetes	345	6.3	6.2	4.9		7.4	6.2
Depression	643	11.8	8.6	3.8		12.9	7.3
Epilepsy	35	0.6	0.8	0.4		1.2	0.8
Heart Failure	46	0.7	0.6	0.3		0.9	0.6
Hypertension	1164	17.3	14.3	8.4		18.3	14.6
Learning disability	56	0.8	0.4	0.2		1.2	0.4
Mental health	30	0.4	0.7	0.4		1.4	0.8
Obesity	509	7.6	7.5	3.9		10.8	7.2
Palliative Care	15	0.2	0.1	0.0		0.5	0.2
Stroke	122	1.8	1.8	0.9		2.9	1.8

Ashford CCG clinical network profile, February 2016

8.2 Recorded prevalence: trend analysis

Trend analysis has been carried out to explore the general practice rate of change for long term condition recorded prevalence between 2006/07 to 2014/15. This has been compared with the national rate of change, as the most reliable estimate.

8.2.1 Rural clinical network

Between 2006/07 and 2014/15, Rural clinical network had a significantly higher rate of change for hypertension, cancer, atrial fibrillation and CHD, and a significantly lower rate of change for obesity.
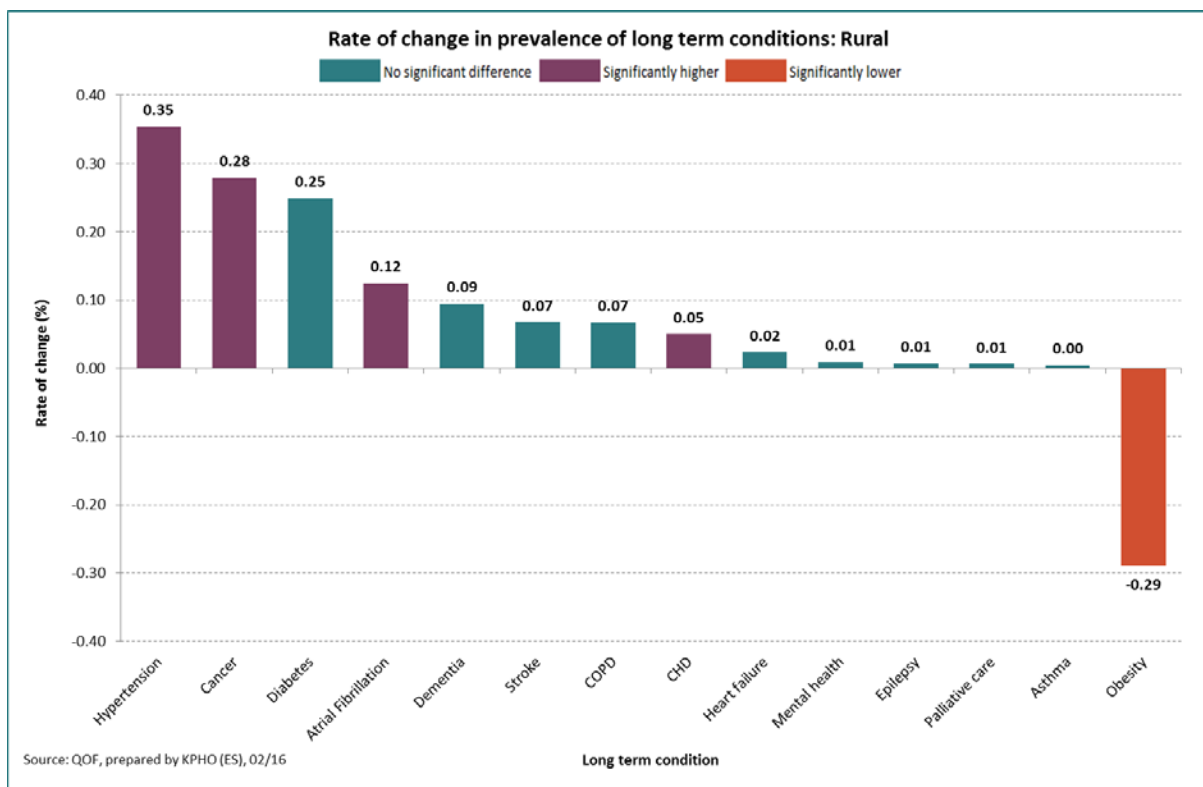
8.2.2 G82053 - Woodchurch Surgery

The annual rate of change for hypertension, cancer, atrial fibrillation, dementia, COPD, CHD and stroke has been significantly higher at Woodchurch Surgery in comparison to the national rate of change in prevalence between 2006/07 to 2014/15.

Rate of change in prevalence of long term conditions: Woodchurch Surgery (G82053)
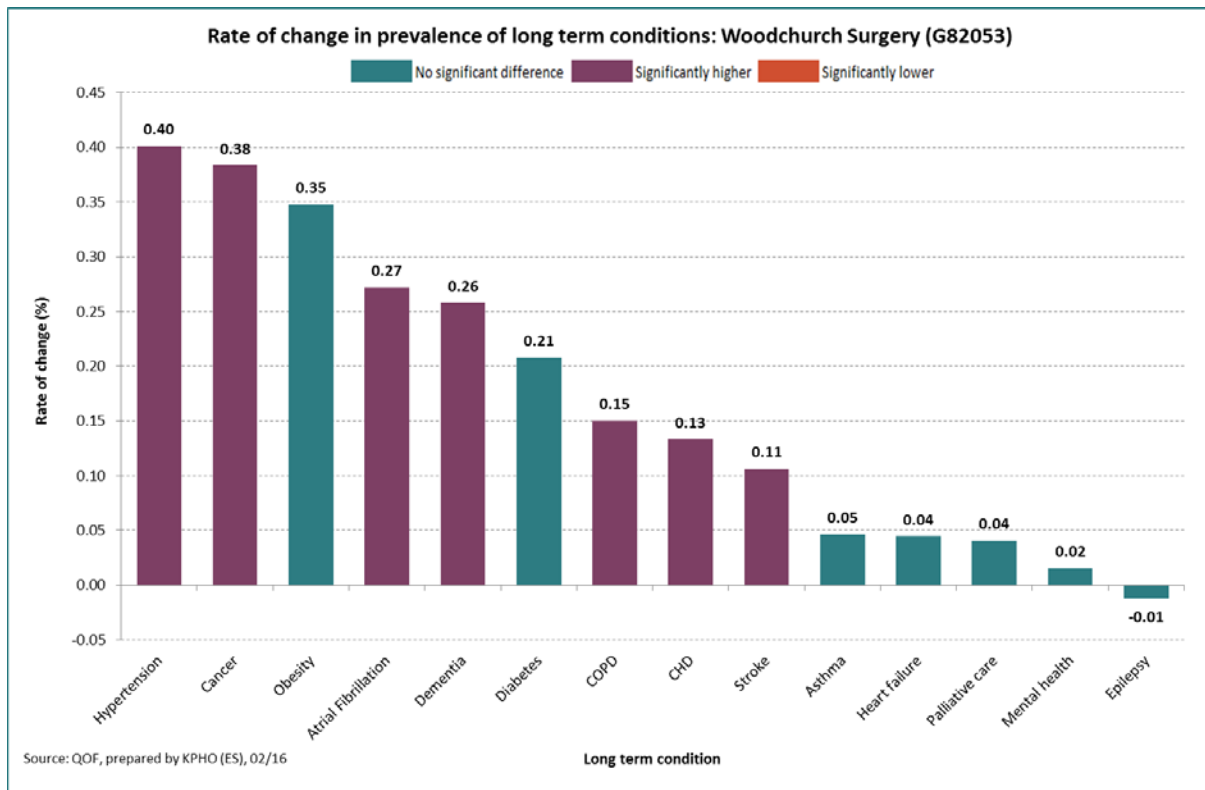
8.2.3 G82114 - Ivy Court Surgery

The annual rate of change for cancer and atrial fibrillation has been significantly higher at Woodchurch Surgery in comparison to the national rate of change in prevalence between 2006/07 to 2014/15, while the rate of change for obesity has been significantly lower.

Rate of change in prevalence of long term conditions: Ivy Court Surgery (G82114)
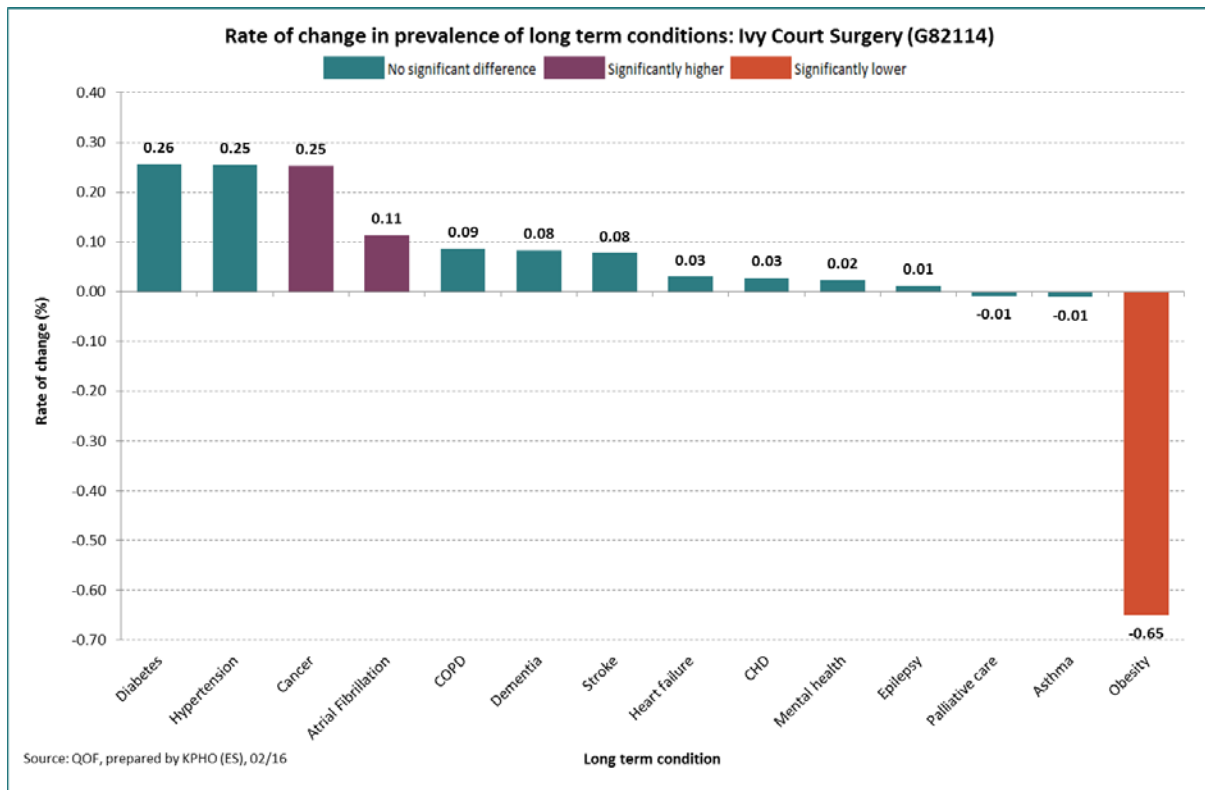
8.2.4 G82186 - Ham Street Surgery

Ham Street Surgery has had a significantly higher rate of change in prevalence in comparison to England for hypertension, cancer and CHD, and a significantly lower rate of change for COPD between 2006/07 and 2014/15.

Rate of change in prevalence of long term conditions: Ham Street Surgery (G82186)

Ashford CCG clinical network profile, February 2016
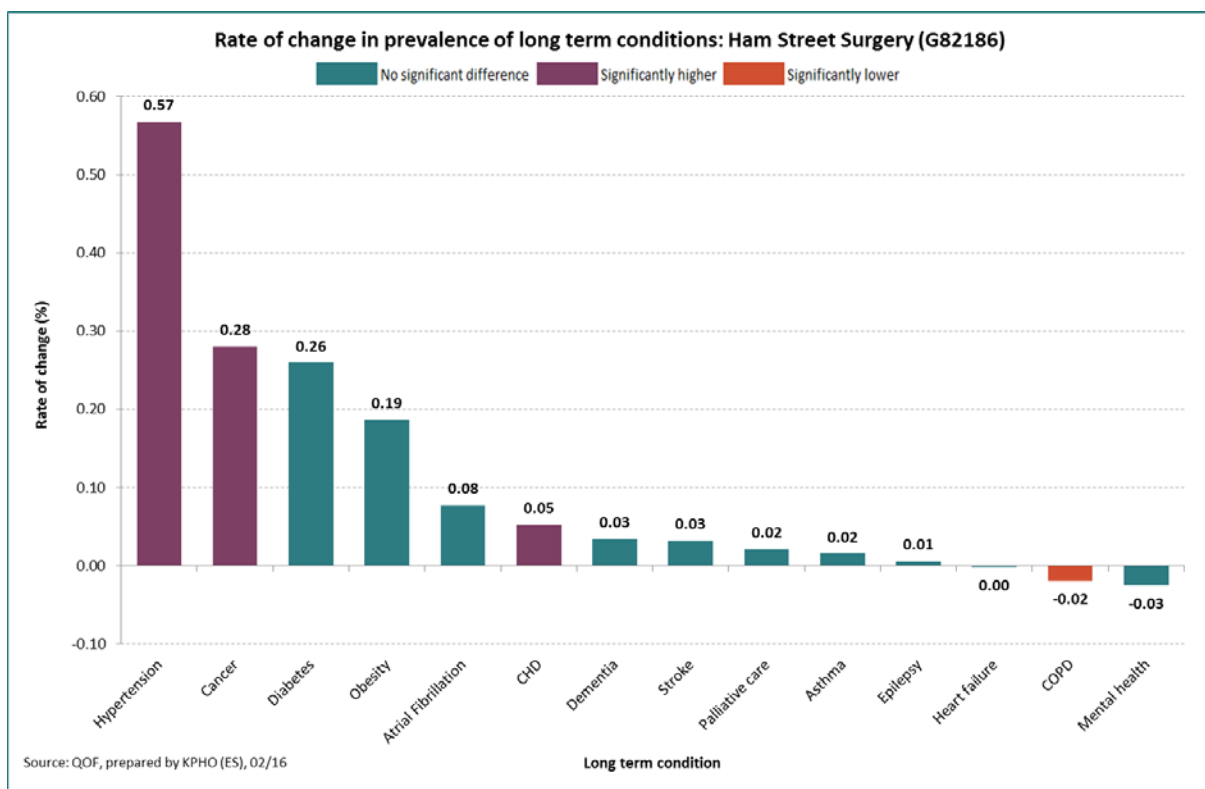
8.3   Recorded and expected prevalence

Recorded prevalence of the conditions of interest are compared to an estimated prevalence rate of each condition for the population of each practice in turn and the aggregated areas. This allows us to calculate an estimation of the proportion of any condition which has been diagnosed. Recorded prevalence of each condition is sourced from QOF (2014/15).

Estimated prevalence at practice level was available for the following conditions:

- Atrial fibrillation (2015, source: Public Health England)
- Coronary heart disease (2011, source: APHO)
- Hypertension (2011, source: APHO)
- Stroke (2011, source: APHO)
- COPD (2011, source: APHO)
- Dementia (2012, source: Primary Care Web Tool)

These estimations will have used a model applied to a breakdown of practice populations by age and risk groups.

To give the reader an idea of the expected prevalence in each area, the figure aggregated for Ashford Rural Network is quoted within each condition section below.

8.3.1   Atrial fibrillation

Atrial fibrillation is estimated to be prevalent in 2.74% of the DULT POPULATION OF THE Ashfprd Rural Network; if this is correct, 86.9% of these cases have been diagnosed, slightly lower than the CCG (91.3%) average, but higher than the Kent (73.3%) average

Source: QOF (14/15), PHE (2015), prepared by KPHO (NH), Feb 2016
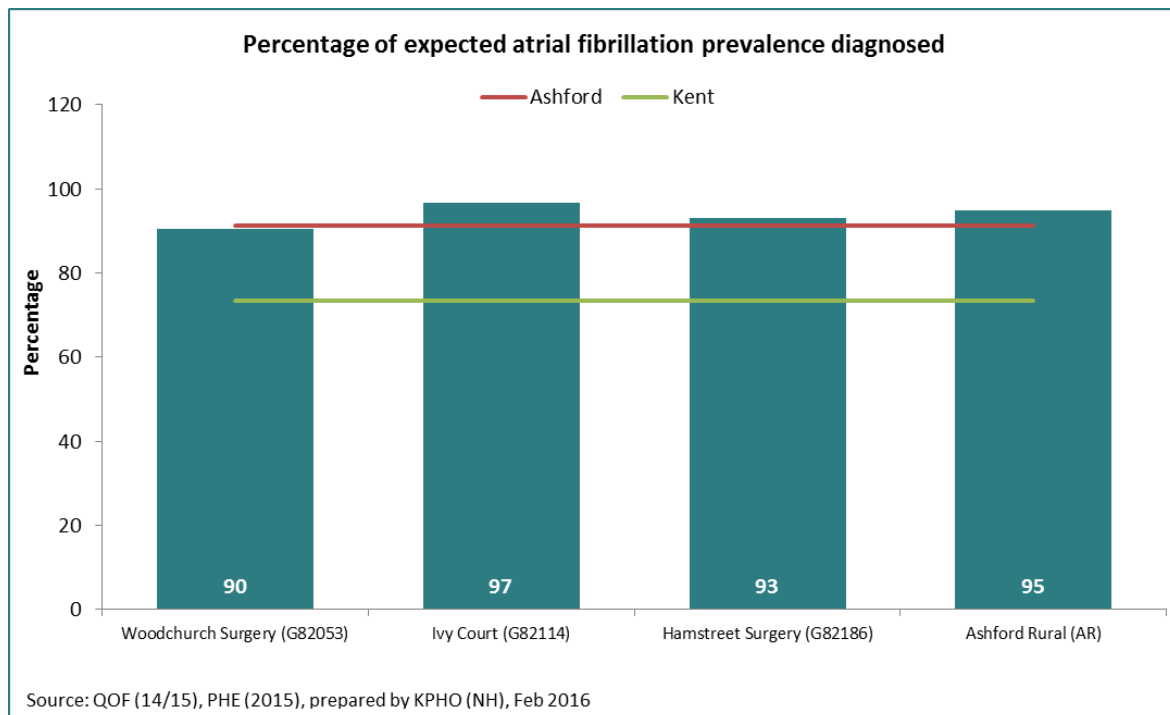
8.3.2   Coronary heart disease

Coronary heart disease (CHD) is estimated to be prevalent in 5.6% of the registered adult population of Ashford Rural Network. On average 73.5% of these expected CHD cases have been detected, this is higher than both the Ashford average (71.4%) and that for Kent (65.0%). Across three practices the within the Rural network detection rates vary widely from 65.8% (Ivy Court) to 92.3% (Woodchurch).
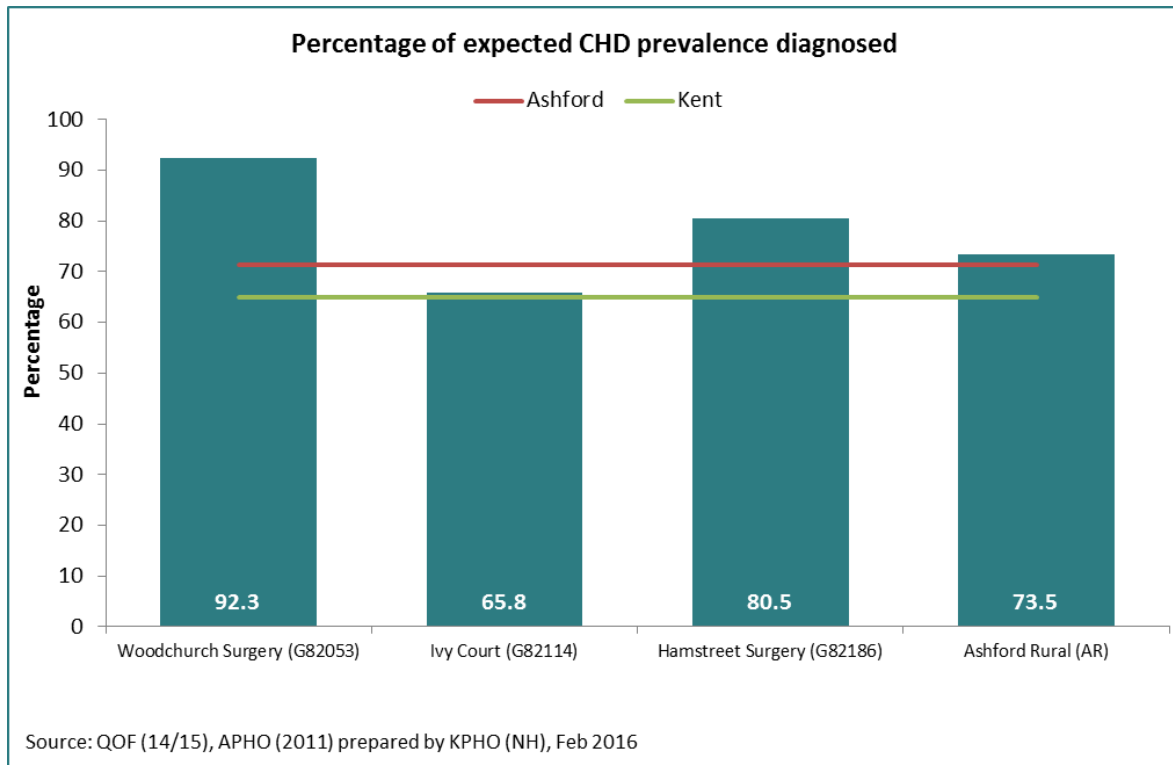
8.3.3 Hypertension

Hypertension is estimated to have a prevalence of 20.4% among the registered adult population of Ashford South Network. Detection of hypertension is at 60.4% of expected cases on average, and is over 60% at two of the three practices; this compares well with both Ashford (58.4%) and Kent (57.3%). Detection at Woodchurch Surgery is lower than these averages.

Percentage of expected hypertension prevalence diagnosed

Source: QOF (14/15), APHO (2011), prepared by KPHO (NH), Feb 2016
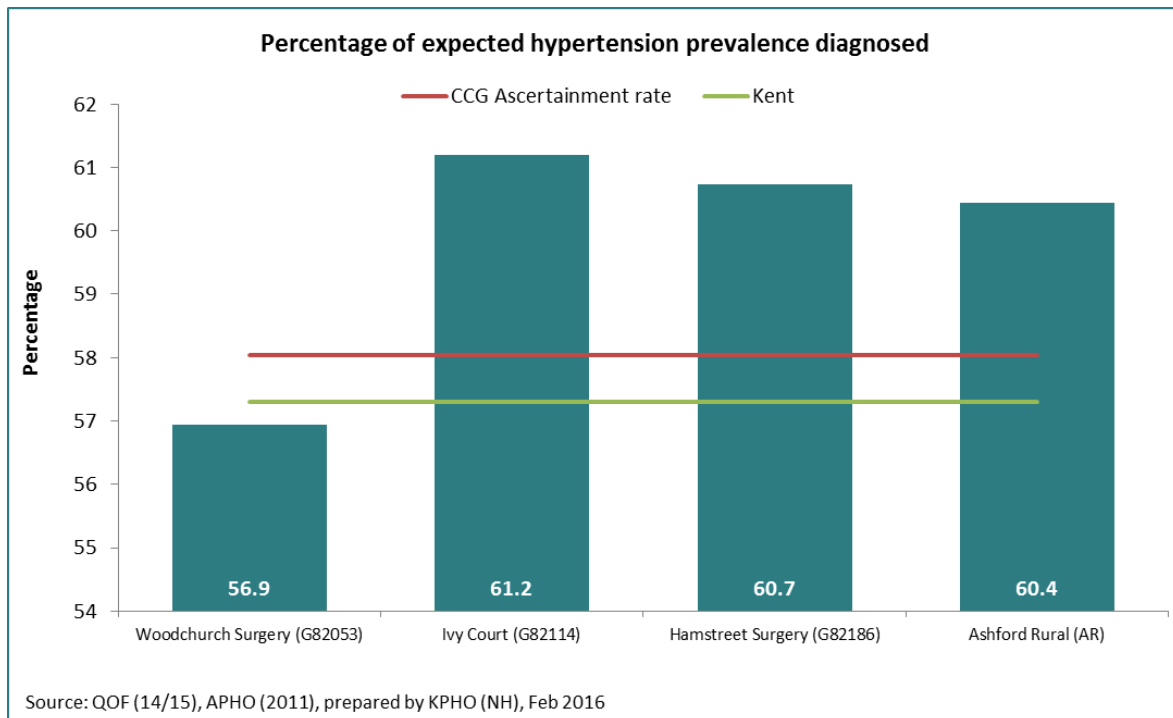
8.3.4 Stroke

Stroke and TIA is estimated to be prevalent in 1.47% of the adult population of Ashford Rural Network. Diagnosed prevalence of stroke and TIA within the rural network is recorded at 98.9% of the expected prevalence on average, and the data suggests all cases are diagnosed at two (Woodchurch Surgery and Ivy Court) of the three practices.

Percentage of expected stroke and TIA prevalence diagnosed

Source: QOF (14/15), APHO (2011), prepared by KPHO (NH), Feb 2016

Ashford CCG clinical network profile, February 2016
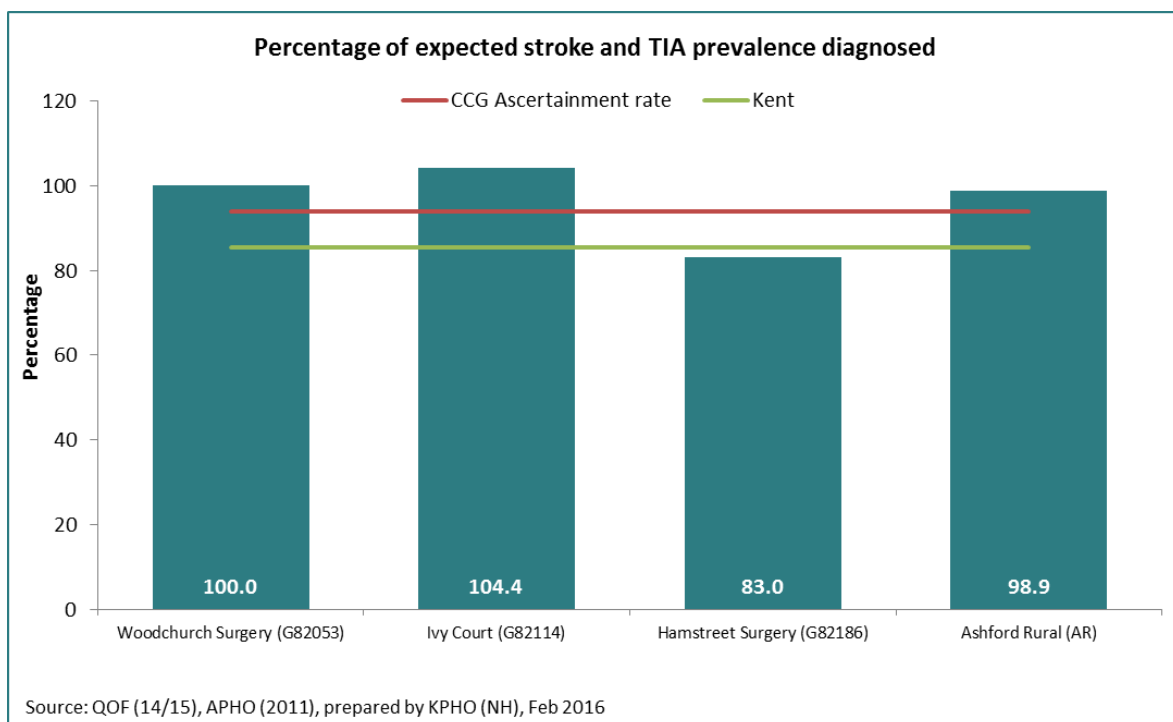
8.3.5 COPD

Chronic Obstructive Pulmonary disease is estimated to be prevalent in 2.43% of the adult registered population of Ashford Rural. Percentage of these expected cases diagnosed averages at 66.3% across the Rural Network, this is lower than both Ashford (70.4%) and Kent (71.1%). Detection is highest at Woodchurch Surgery (74.7%) and lower at both Ivy Court (66.7%) and Hamstreet Surgery (60.6%).

Percentage of expected COPD prevalence diagnosed

Source: QOF (14/15), APHO (2011), prepared by KPHO (NH), Feb 2016
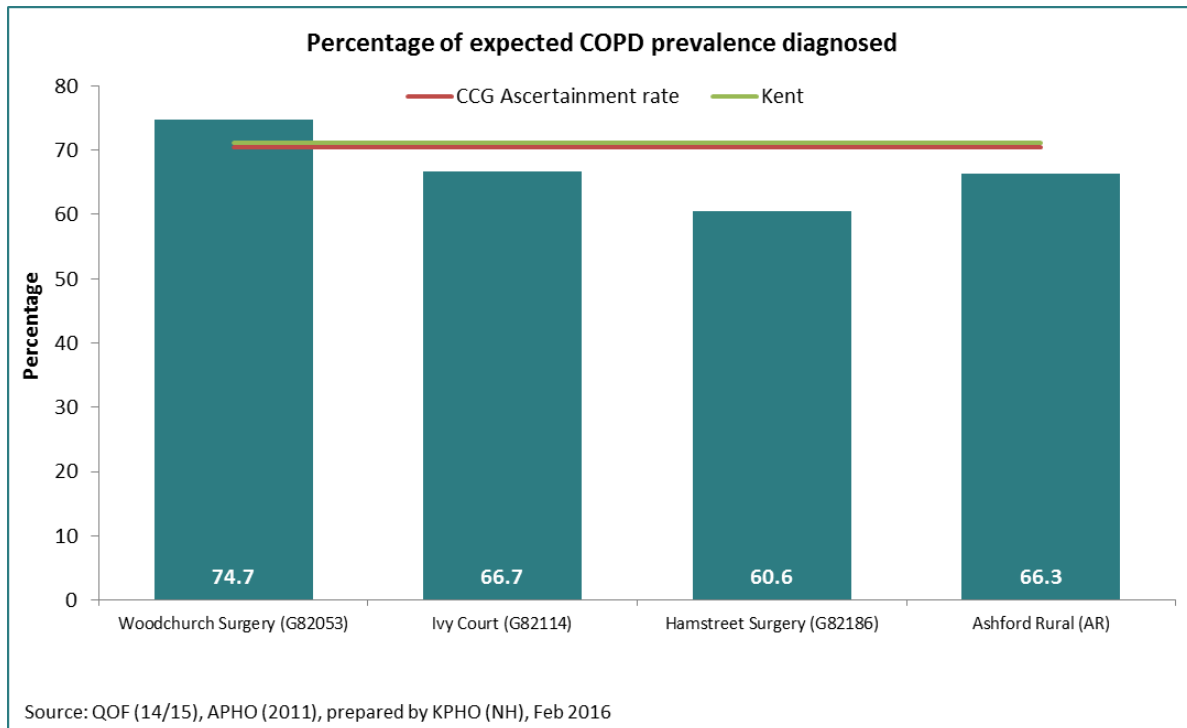
8.3.6 Dementia

Dementia is estimated to have a prevalence of 0.82% in the adult registered population of Ashford Rural Network. Of this figure, 53.3% of cases have been diagnosed on average across the Rural network, this figure is between that for Ashford CCG (51.8%) and Kent (54.6%). Detection of expected cases is particularly high (91.0%) at Woodchurch Surgery. It is low (33.2%) at Hamstreet Surgery.

Ashford CCG clinical network profile, February 2016

Percentage of expected dementia prevalence diagnosed

Source: QOF (14/15), Primary Care web tool (2011), prepared by KPHO (NH), Feb 2016
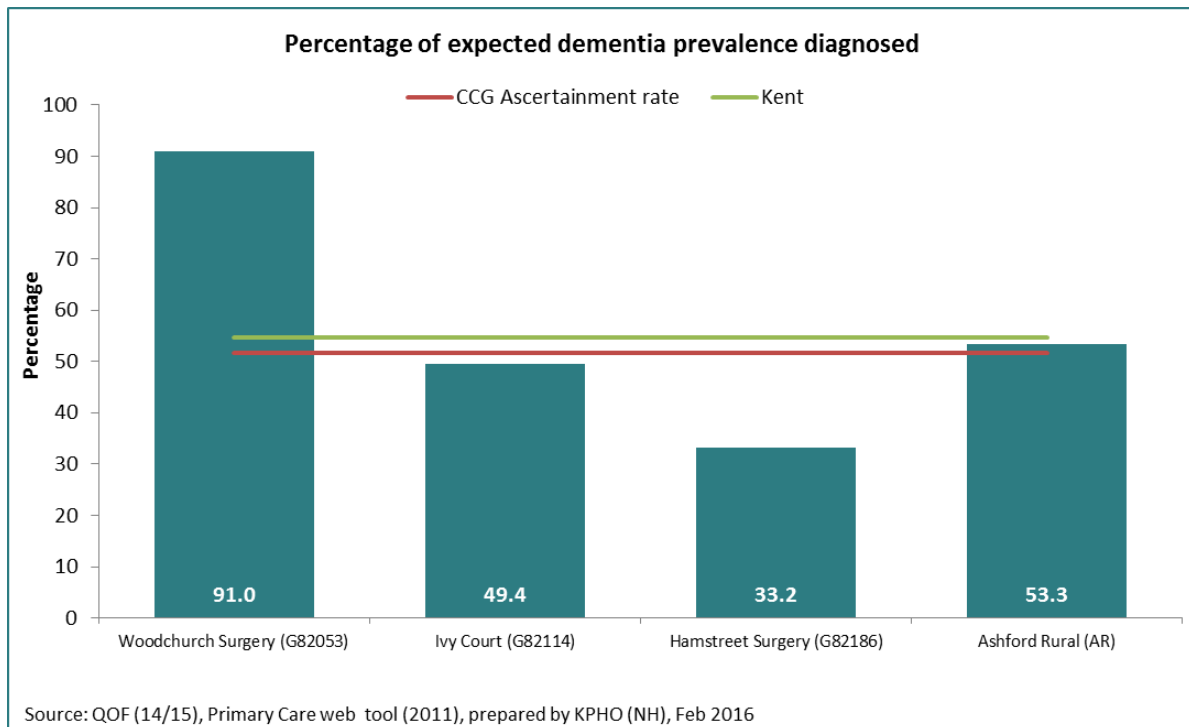
8.4 Clinical achievement

Spine charts have been produced to compare the general practice clinical achievement for long term conditions within Ashford CCG for 2014/15.

The clinical achievement indicator definitions have been included in Appendix A.
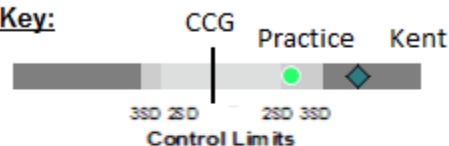
8.4.1 Rural clinical network

In 2014/15 Ashford Rural network had significantly higher clinical achievement when compared to Ashford CCG for the following indicators:

- Asthma 002
- COPD003
- COPD004
- Diabetes 003
- Diabetes 007

- Diabetes 009
- Diabetes 014
- Mental Health 002
- Stroke and TIA 003

In 2014/15 Ashford Rural network did not have any significantly lower achievements than Ashford CCG.

| Indicator | Rural community network | | CCG | | | | | Kent |
	Number	Achievement	Achievement	CCG lowest	CCG	CCG highest	achievement
Asthma 002	386	91.5	86.0	77.4		97.3	86.6
Asthma 003	1001	72.0	71.2	52.2		85.1	72.2
CHD 002	375	90.1	89.2	60.5		96.2	92.0
CHD 006	352	86.3	84.8	52.6		95.7	97.6
COPD 003	922	92.6	90.1	79.3		97.4	88.4
COPD 004	64	100.0	96.5	69.6		100.0	85.2
Diabetes 003	1095	85.5	78.4	58.4		97.0	77.6
Diabetes 007	925	78.6	72.2	61.3		85.1	71.0
Diabetes 009	1158	91.9	88.2	79.0		95.8	87.5
Diabetes 014	31	100.0	90.5	8.3		100.0	89.4
Mental health 002	101	96.2	86.0	35.3		100.0	86.2
Stroke and TIA 003	552	90.0	84.9	69.0		96.6	87.3

8.4.2 G82053 - Woodchurch Surgery

In 2014/15 Woodchurch Surgery had significantly higher clinical achievement when compared to Ashford CCG for the following indicators:

- Asthma 002
- Asthma 003
- CHD002
- CHD006
- COPD003
- COPD004
- Diabetes 003
- Diabetes 009
- Diabetes 014
- Mental Health 002
- Stroke and TIA 003

In 2014/15 Woodchurch Surgery did not have any significantly lower achievements than Ashford CCG.

| Indicator | G82053 Woodchurch Surgery | | CCG | | | | Kent |
	Number	Achievement	Achievement	CCG lowest	CCG	CCG highest	achievement
Asthma 002	73	97.3	86.0	77.4		97.3	86.6
Asthma 003	222	85.1	71.2	52.2		85.1	72.2
CHD 002	75	96.2	89.2	60.5		96.2	92.0
CHD 006	67	95.7	84.8	52.6		95.7	97.6
COPD 003	189	97.4	90.1	79.3		97.4	88.4
COPD 004	11	100.0	96.5	69.6		100.0	85.2
Diabetes 003	193	97.0	78.4	58.4		97.0	77.6
Diabetes 007	151	77.8	72.2	61.3		85.1	71.0
Diabetes 009	183	92.9	88.2	79.0		95.8	87.5
Diabetes 014	10	100.0	90.5	8.3		100.0	89.4
Mental health 002	14	100.0	86.0	35.3		100.0	86.2
Stroke and TIA 003	84	93.3	84.9	69.0		96.6	87.3

8.4.3 G82114 - Ivy Court Surgery

In 2014/15 Ivy Court Surgery had significantly higher clinical achievement when compared to Ashford CCG for the following indicators:

- Asthma 002
- COPD004
- Diabetes 003
- Diabetes 007
- Diabetes 009
- Diabetes 014
- Mental Health 002

In 2014/15 Ivy Court Surgery did not have any significantly lower achievements than Ashford CCG.

| Indicator | G82114 Ivy Court Surgery | | CCG | | | | Kent |
	Number	Achievement	Achievement	CCG lowest	CCG	CCG highest	achievement
Asthma 002	208	91.2	86.0	77.4		97.3	86.6
Asthma 003	538	72.7	71.2	52.2		85.1	72.2
CHD 002	215	91.9	89.2	60.5		96.2	92.0
CHD 006	204	87.6	84.8	52.6		95.7	97.6
COPD 003	482	91.3	90.1	79.3		97.4	88.4
COPD 004	31	100.0	96.5	69.6		100.0	85.2
Diabetes 003	628	83.6	78.4	58.4		97.0	77.6
Diabetes 007	559	85.1	72.2	61.3		85.1	71.0
Diabetes 009	700	95.8	88.2	79.0		95.8	87.5
Diabetes 014	14	100.0	90.5	8.3		100.0	89.4
Mental health 002	59	93.7	86.0	35.3		100.0	86.2
Stroke and TIA 003	355	88.1	84.9	69.0		96.6	87.3

8.4.4 G82186 - Ham Street Surgery

In 2014/15 Ham Street Surgery had significantly higher clinical achievement when compared to Ashford CCG for the following indicators:

- COPD 004
- Diabetes 003
- Diabetes 014
- Mental Health 002
- Stroke and TIA 003

In 2014/15 Ham Street Surgery had significantly lower clinical achievement when compared to Ashford CCG for the following indicators:

- Asthma 003
- Diabetes 007
- Diabetes 009

Indicator	G82186 Ham Street Surgery		CCG					Kent
	Number	Achievement	Achievement	CCG lowest	CCG		CCG highest	achievement
Asthma 002	105	88.2	86.0	77.4			97.3	86.6
Asthma 003	241	62.0	71.2	52.2			85.1	72.2
CHD 002	85	81.7	89.2	60.5			96.2	92.0
CHD 006	81	77.1	84.8	52.6			95.7	97.6
COPD 003	251	91.6	90.1	79.3			97.4	88.4
COPD 004	22	100.0	96.5	69.6			100.0	85.2
Diabetes 003	274	83.0	78.4	58.4			97.0	77.6
Diabetes 007	215	66.0	72.2	61.3			85.1	71.0
Diabetes 009	275	82.8	88.2	79.0			95.8	87.5
Diabetes 014	7	100.0	90.5	8.3			100.0	89.4
Mental health 002	28	100.0	86.0	35.3			100.0	86.2
Stroke and TIA 003	113	94.2	84.9	69.0			96.6	87.3

Ashford CCG clinical network profile, February 2016

| 9. Hospital activity

9.1 Emergency Hospital Admissions

The following Chapter explores the level of emergency hospital admissions in the under 75 population. This has focused on the ambulatory care sensitive conditions, including; asthma, chronic obstructive pulmonary disease and diabetes complications, as well as, a range of other diagnoses. High levels of emergency admissions for the ambulatory care sensitive conditions may indicate potentially preventable admissions.

Notes on methodology:

- Age standardised rates have been presented to enable comparison of the practice networks without confounding by age.
- An analysis of trend and rate of change has been presented for the practice networks for the period 2006/07 to 2014/15. This has been compared to the CCG and Kent.
- An analysis by general practice has been presented, often in the case of small numbers; this has been presented for the pooled years 2006/07 – 2014/15. This has been compared to the CCG and Kent.

The key below differentiates between the general practices in each clinical network.

	North Community Network
	Rural Community Network
	South Community Network
	Ashford CCG

9.1.1 Emergency Hospital Admissions

For Rural, the age standardised rate of emergency hospital admissions in the under 75 population shows a steady trend between 2006/07 and 2014/15. The rate of change for Rural (349.9, per 100,000 population) is higher than the Ashford CCG (157.9).

The age standardised rate of emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

The rate of change for the age standardised rate of emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

Ashford CCG clinical network profile, February 2016

The age standardised rate, for emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

General Practice and Ashford CCG

All general practices in Rural clinical Network show a significantly lower age standardised rate for emergency hospital admissions, per 100,000 population.

9.1.2   Asthma

For Rural, the age standardised rate of asthma emergency hospital admissions in the under 75 population has shown an increasing trend between 2006/07 and 2014/15. The rate of change for Rural (3.7, per 100,000 population) is increasing higher than Ashford CCG (2.8).

Ashford CCG clinical network profile, February 2016

The age standardised rate of asthmatic emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

The rate of change for the age standardised rate of asthamtic emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

Ashford CCG clinical network profile, February 2016

The age standardised rate of asthmatic emergency hospital admissions, per 100,000 population, 2011/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

A significantly lower age standardised rate for asthmatic emergency hospital admissions, per 100,000 population, can be identified for Woodchurch Surgery and Ham Street Surgery.

9.1.3 Coronary Heart Disease

For Rural, the age standardised rate of coronary heart disease emergency hospital admissions in the under 75 population has shown a decreasing trend between 2006/07 and 2014/15. The rate of change for Rural (-1.1, per 100,000 population) is decreasing at a slower rate than Ashford CCG (-1.3).

The age standardised rate of coronary heart disease (CHD) emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

The rate of change for the age standardised rate of coronary heart disease (CHD) emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

Ashford CCG clinical network profile, February 2016

The age standardised rate, for coronary heart disease (CHD) emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

A significantly lower age standardised rate for coronary heart disease emergency hospital admissions, in the under 75 population, per 100,000 population, can be identified for Ivy Court Surgery compared to Ashford CCG.

9.1.4   Chronic Obstructive Pulmonary Disease

For Rural, the age standardised rate of chronic obstructive pulmonary disease emergency hospital admissions in the under 75 population has shown a decreasing trend between 2006/07 and 2014/15. The rate of change for Rural (-2.9, per 100,000 population) is decreasing but is decreasing slower than Ashford CCG (-5.9).

The age standardised rate of chronic obstructive heart disease (COPD), emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

The rate of change for the age standardised rate of chronic obstructive pulmonary disease (COPD) emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

Ashford CCG clinical network profile, February 2016

The age standardised rate, for chronic obstructive pulmonary disease (COPD) emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, under 75

Age standardised rate per 100,000 population

Practice	Rate
Hollington Surgery	176.08
Willesborough Health Centre	104.79
New Hayesbank Surgery	138.34
Charing Practice	128.38
Wye Surgery	164.89
Sellindge Surgery	58.96
Woodchurch Surgery	81.53
Ivy Court Surgery	61.8
Ham Street Surgery	101.16
Sydenham House Surgery	119.41
Singleton Surgery	185.07
Singleton Medical Centre	130.24
Kingsnorth Medical Practice	99.09
South Ashford Medics	272.55
Ashford CCG	119.14

General Practice and Ashford CCG
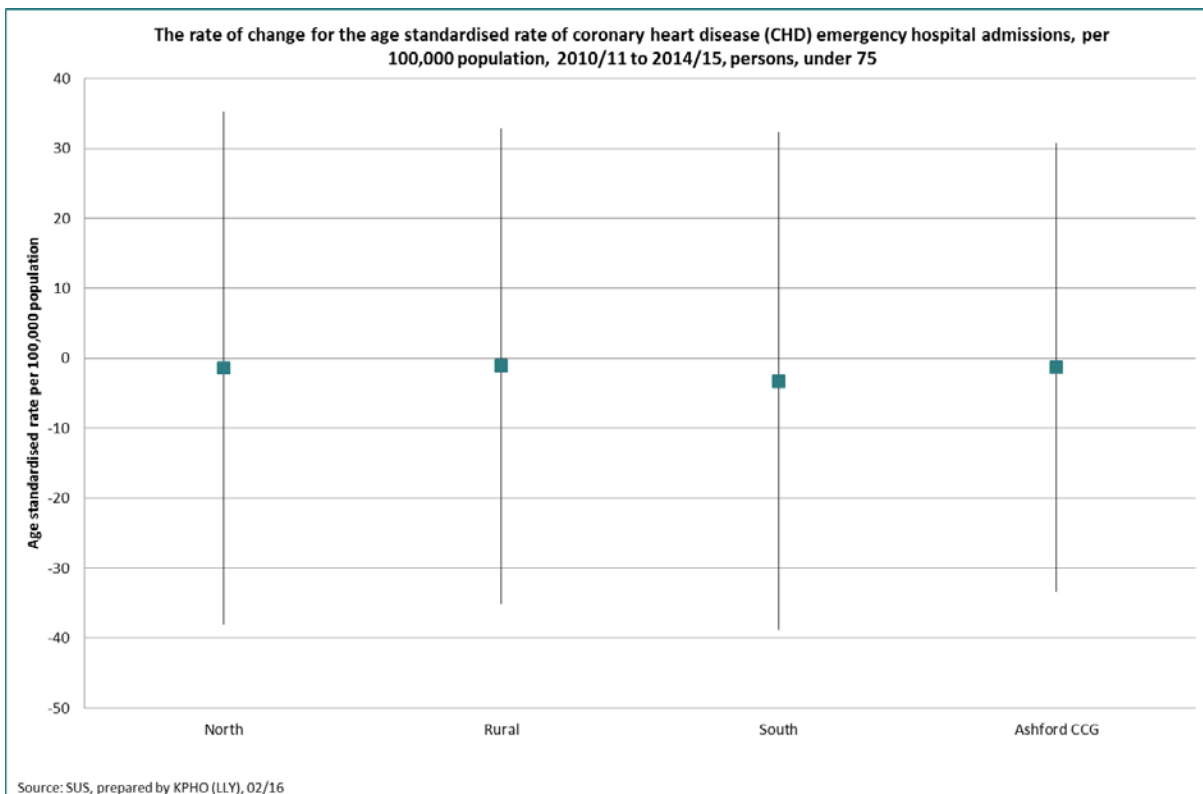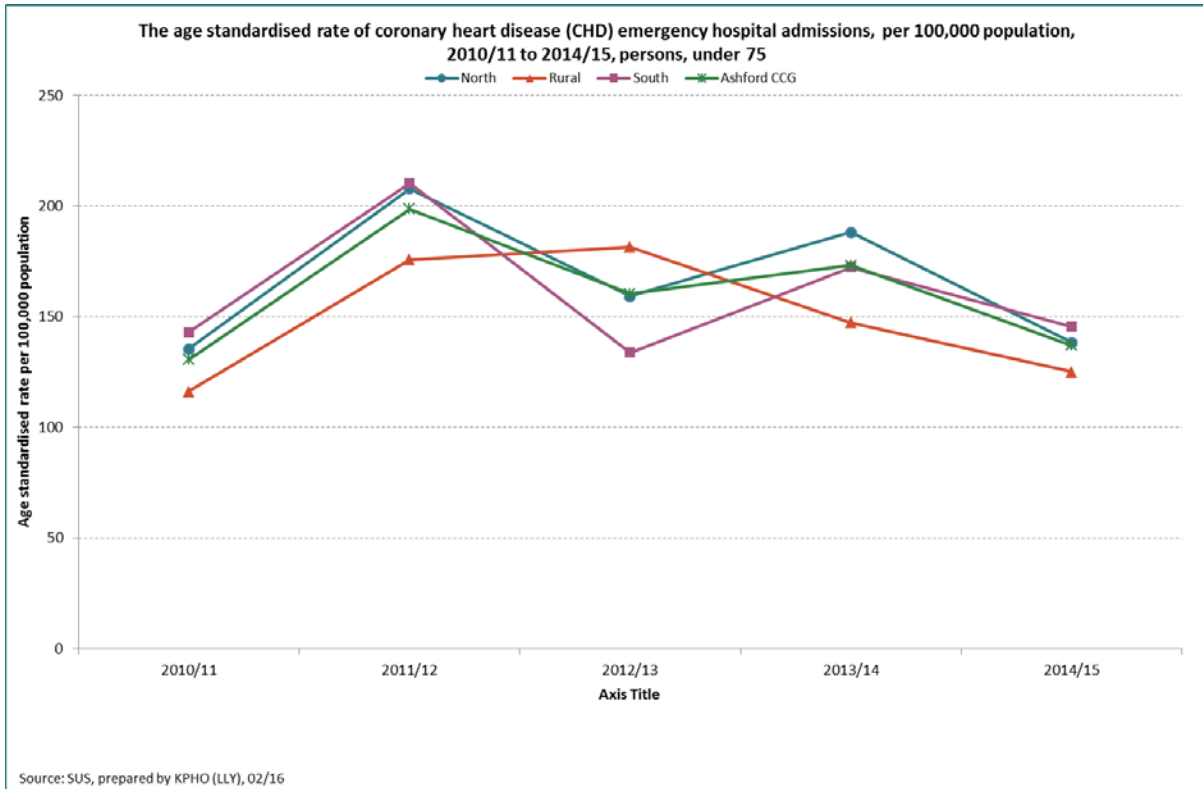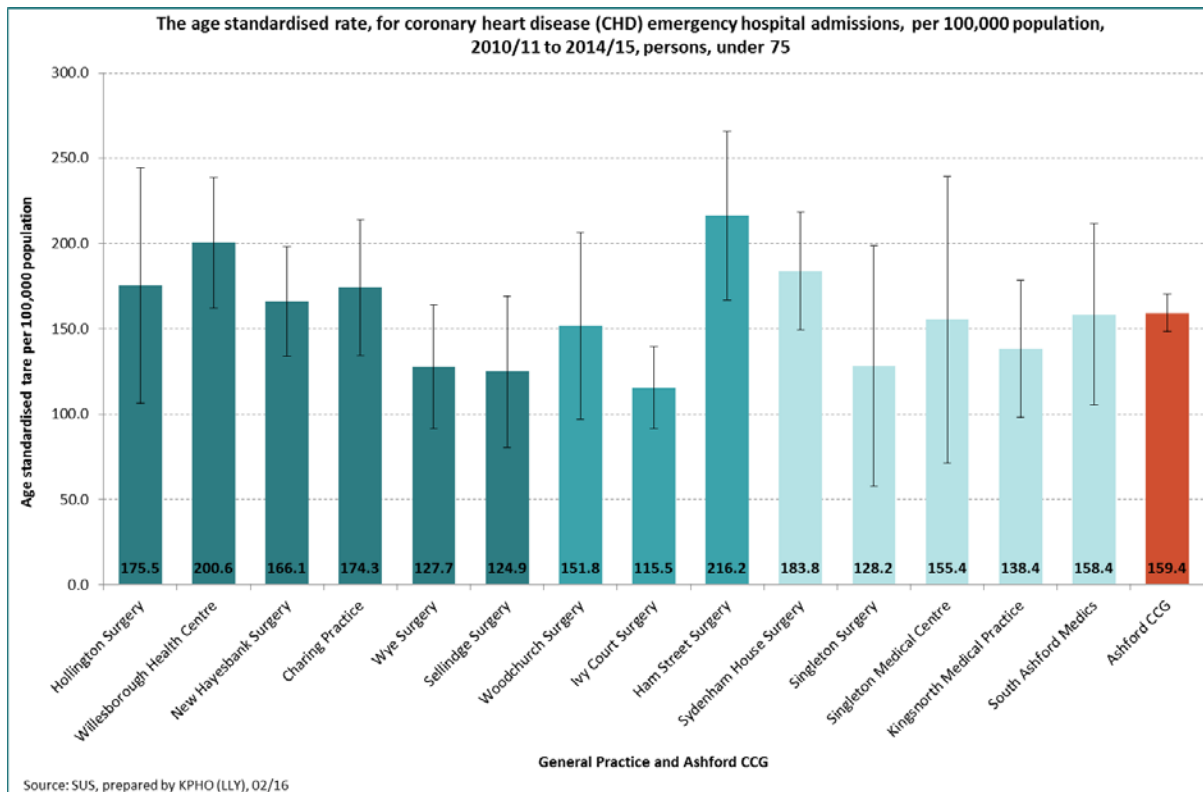
Source: SUS, prepared by KPHO (LLY), 02/16
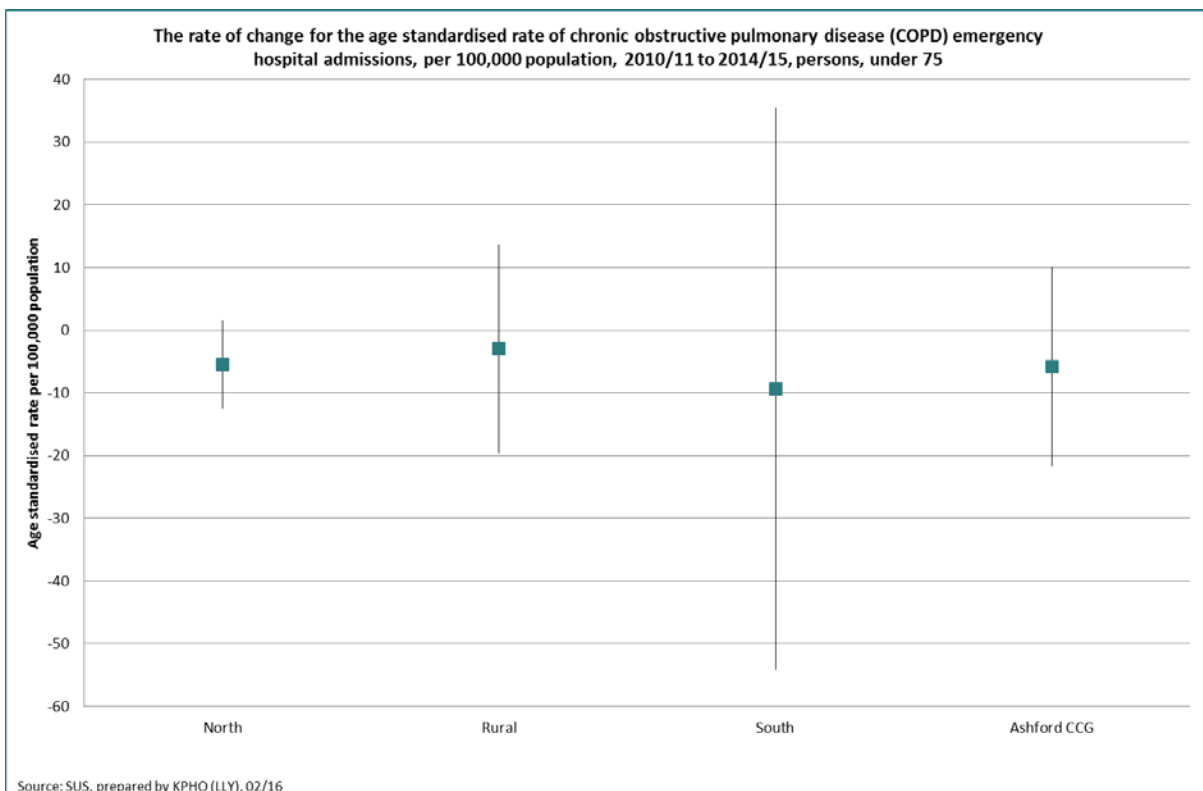
A significantly lower age standardised rate for coronary heart disease emergency hospital admissions, per 100,000 population, can be identified for Ivy Court Surgery.

9.1.5 Diabetes Complications

For Rural, the age standardised rate of diabetes complications emergency hospital admissions in the under 75 population has shown an increasing trend between 2006/07 and 2014/15. The rate of change for diabetes complications emergency hospital admissions is increasing (42.8, per 100,000 population) and is higher than Ashford CCG (34.7).

The age standardised rate for diabetes complications emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

The rate of change for the age standardised rate of diabetes complications emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

Ashford CCG clinical network profile, February 2016

The age standardised rate for diabetes complications emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16
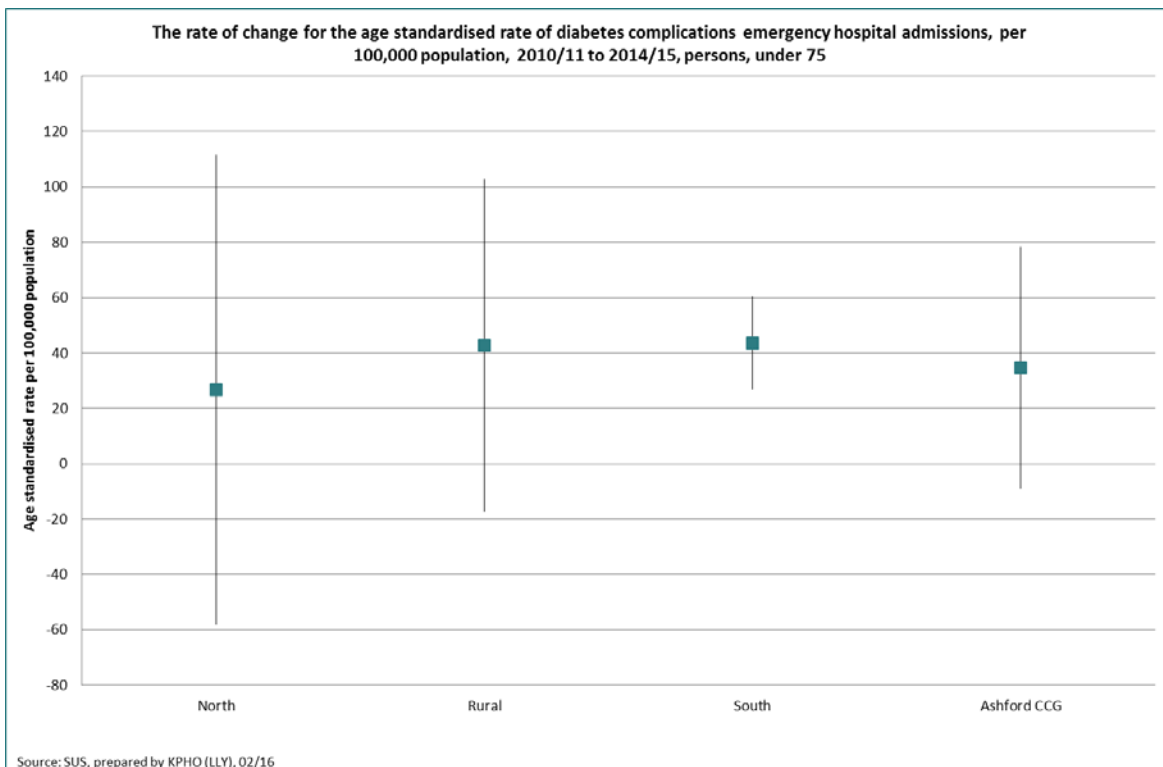
A significantly lower age standardised rate for diabetes complications emergency hospital admissions, per 100,000 population, can be identified for Woodchurch Surgery and Ivy Court Surgery.

9.1.5 Falls

For Rural, the age standardised rate of falls emergency hospital admissions in the under 75 population has shown a decreasing trend between 2006/07 and 2014/15. The rate of change for Rural (1.5, per 100,000 population) has increased between 2010/11 to 2014/15 and is higher than Ashford CCG (-6.6) which is decreasing.

The age standardised rate of falls emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

The rate of change for the age standardised rate of falls emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

Ashford CCG clinical network profile, February 2016

The age standardised rate of falls emergency hospital admissions, per 100,000 population, 2011/11 to 2014/15, persons, under 75

Practice	Rate
Hollington Surgery	236.6
Willesborough Health Centre	299.6
New Hayesbank Surgery	301.4
Charing Practice	307.9
Wye Surgery	290.3
Sellindge Surgery	251.1
Woodchurch Surgery	265.7
Ivy Court Surgery	286.5
Ham Street Surgery	275.0
Sydenham House Surgery	314.9
Singleton Surgery	302.7
Singleton Medical Centre	188.5
Kingsnorth Medical Practice	265.8
South Ashford Medics	325.8
Ashford CCG	289.4

Source: SUS, prepared by KPHO (LLY), 02/16

There were no general practices in Rural clinical Network that were significantly higher or lower than Ashford CCG.

9.1.6   Stroke

For Rural, the age standardised rate of stroke emergency hospital admissions in the under 75 population had decreased between 2006/07 and 2014/15. The rate of change for Rural is decreasing (-4.8) which is decreasing faster than Ashford CCG (-0.9).

Ashford CCG clinical network profile, February 2016

The age standardised rate of stroke emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

The rate of change for the age standardised rate of stroke emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

Ashford CCG clinical network profile, February 2016

The age standardised rate of stroke emergency hospital admissions, per 100,000 population, 2011/11 to 2014/15, persons, under 75

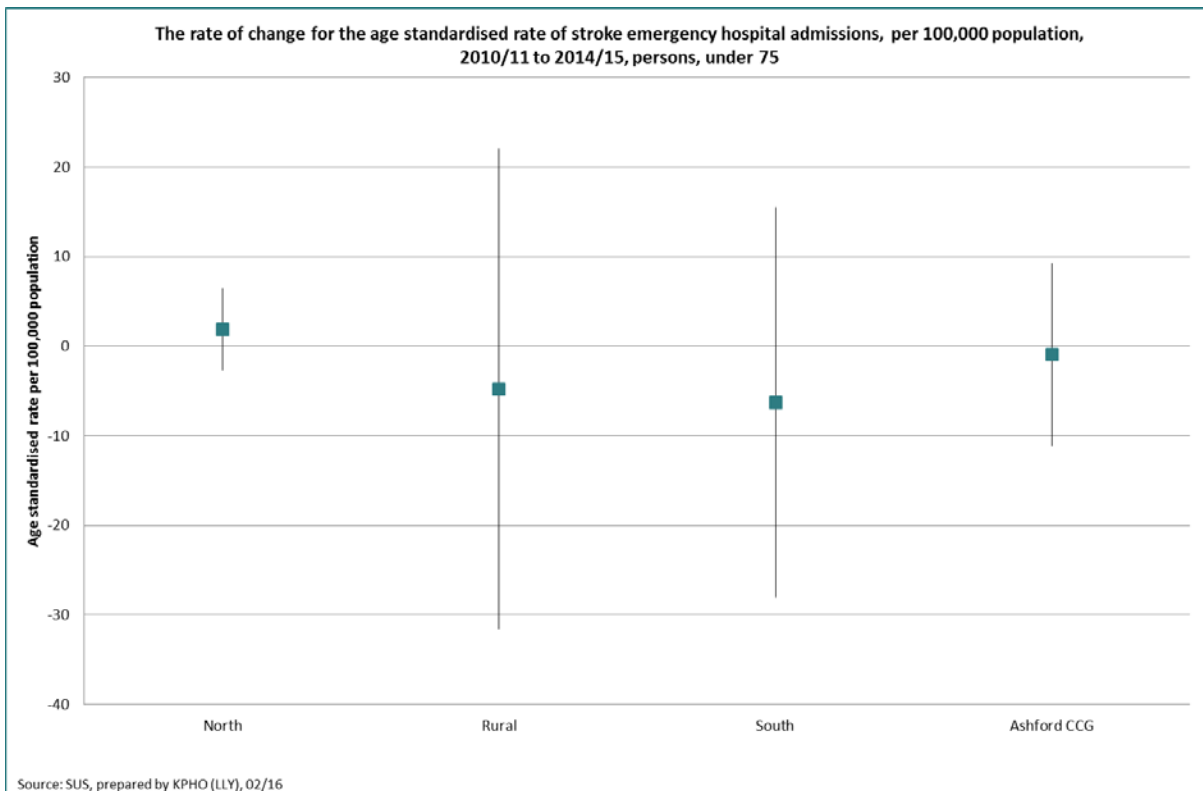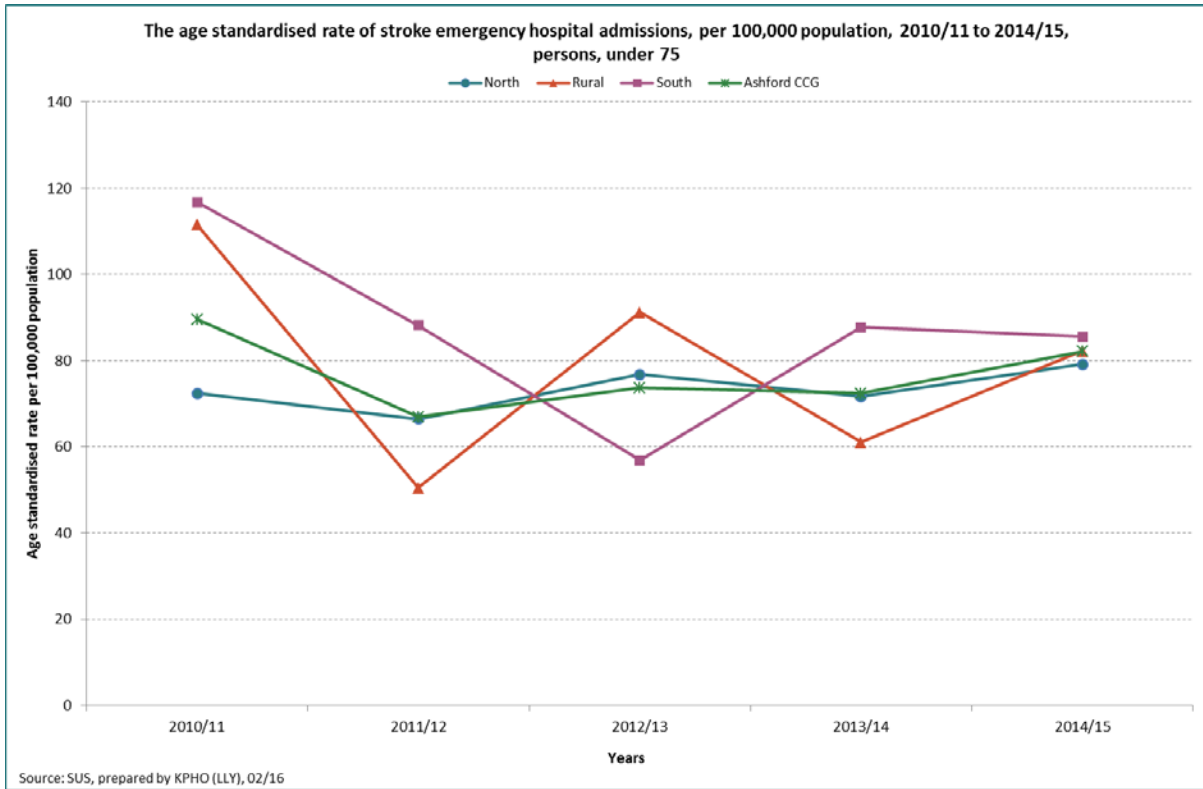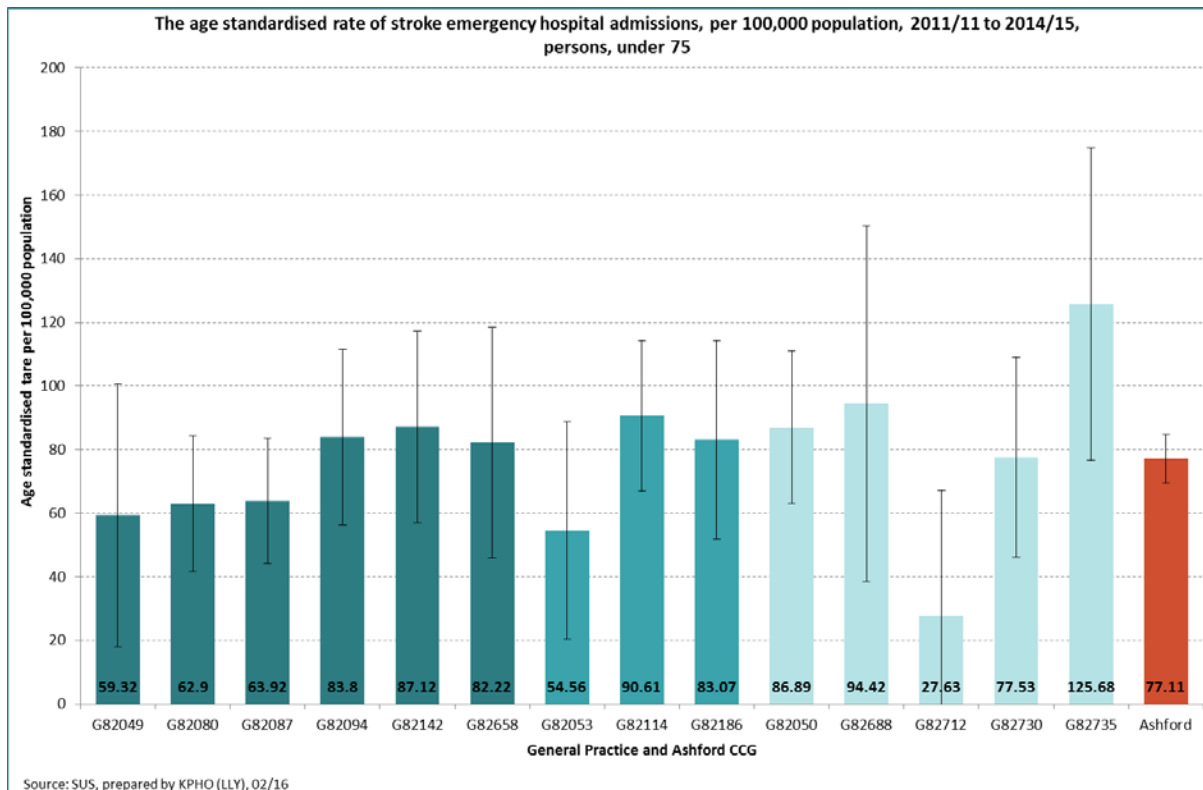Source: SUS, prepared by KPHO (LLY), 02/16

There were no general practices in Rural clinical Network that were significantly higher or lower than Ashford CCG.

9.1.7 Mental Health

For Rural, the age standardised rate of stroke emergency hospital admissions in the under 75 population has shown an increasing trend between 2006/07 and 2014/15. The rate of change for Rural is increasing (17.4, per 100,000 population) at a higher rate than Ashford CCG (0.8).

The age standardised rate of mental health emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

The rate of change for the age standardised rate of mental health emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

Ashford CCG clinical network profile, February 2016

The age standardised rate, for mental health emergency hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, under 75

Source: SUS, prepared by KPHO (LLY), 02/16

General Practice and Ashford CCG
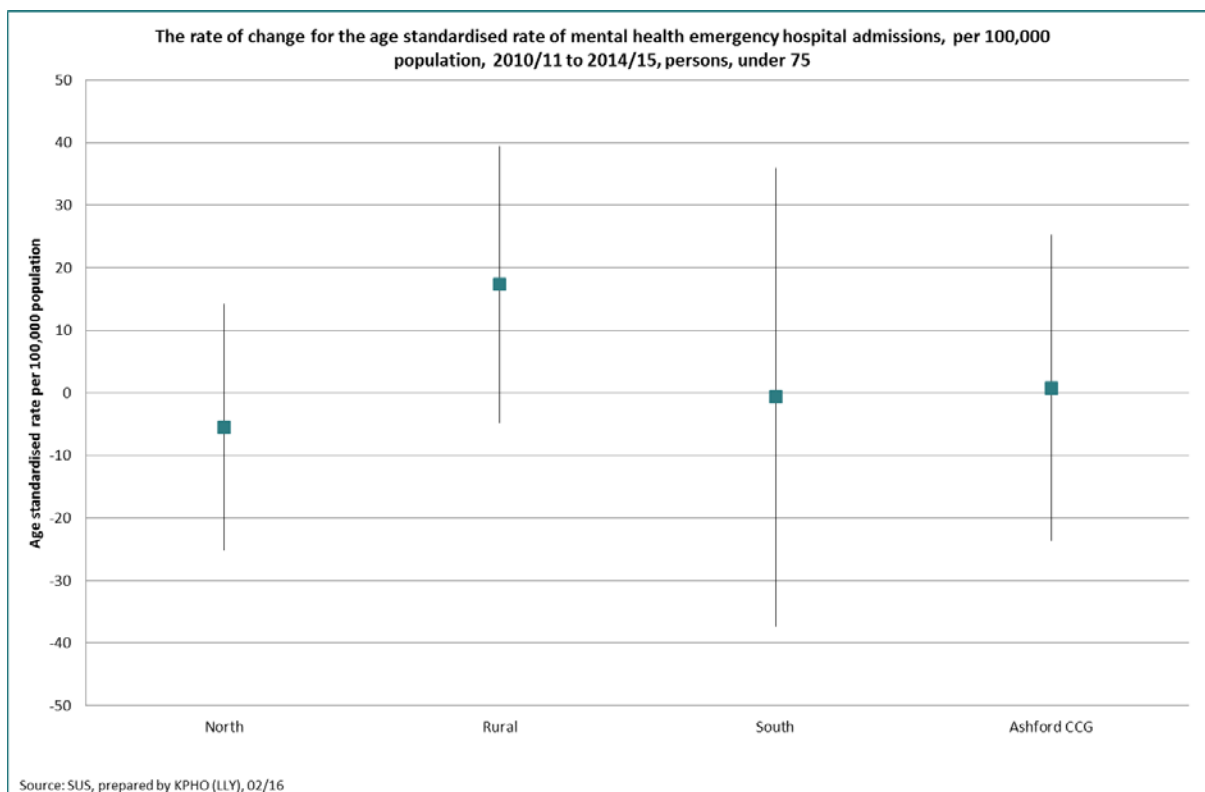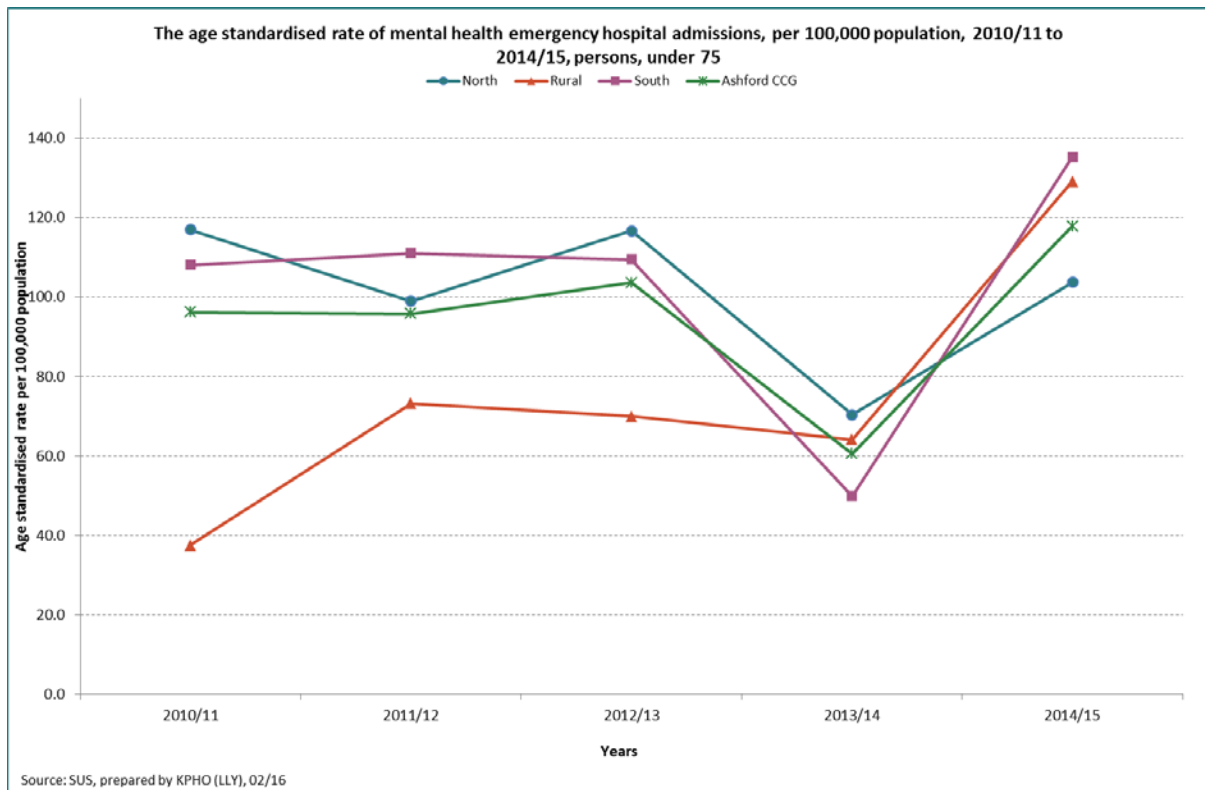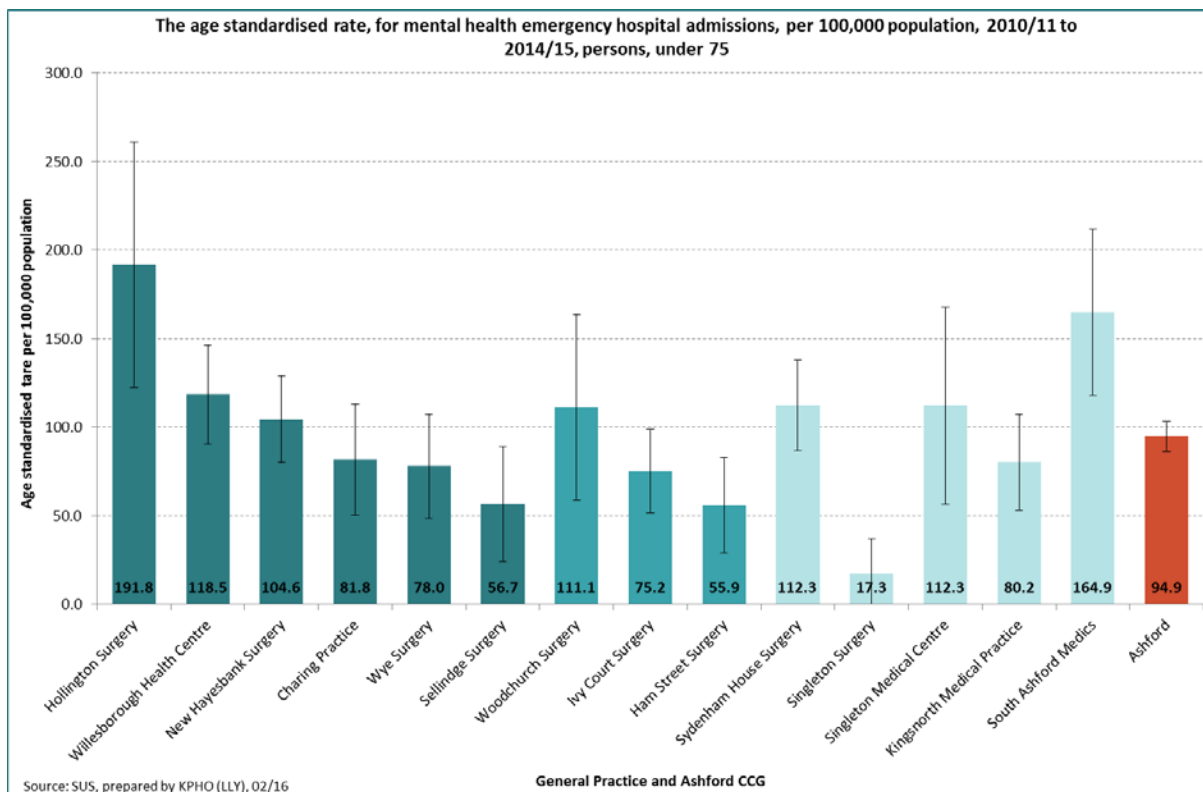
There were no general practices in Rural clinical Network that were significantly higher or lower than Ashford CCG.

9.1 Alcohol Specific Hospital Admissions

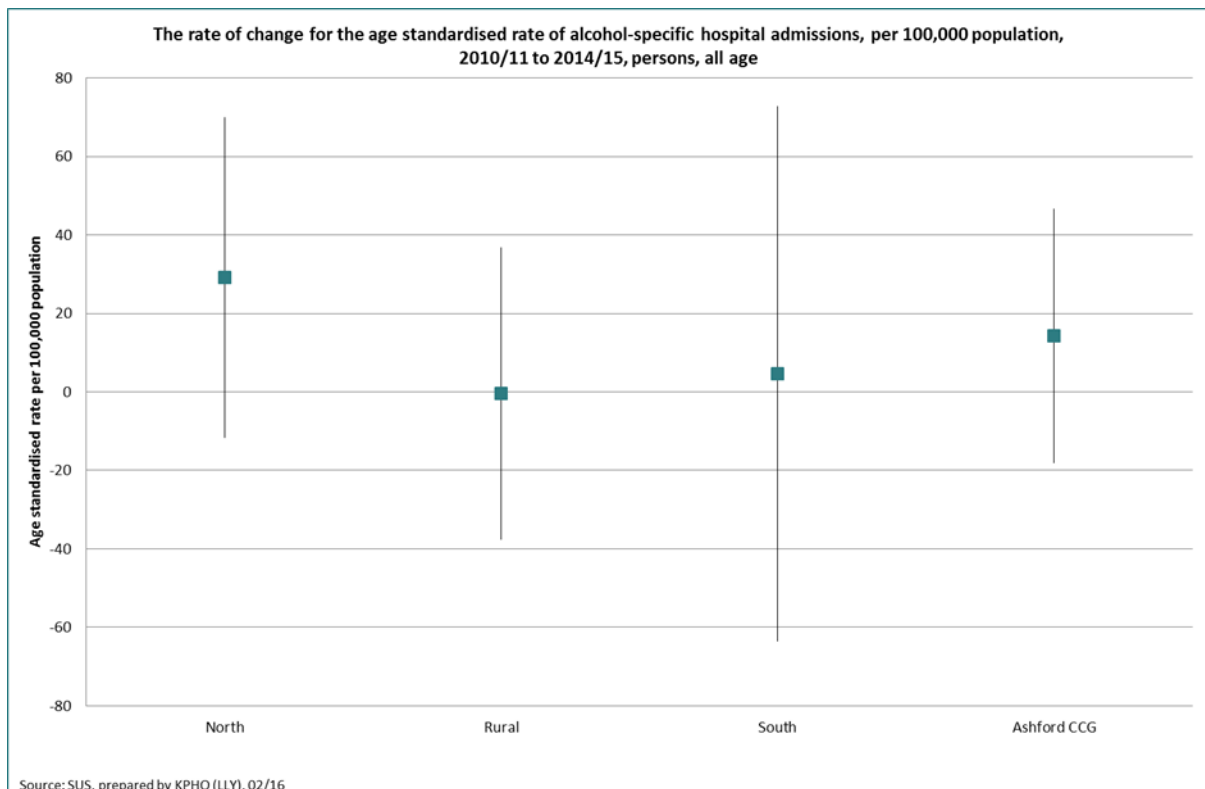The following chapter explores the level of alcohol specific hospital admissions.

Notes on methodology:

- Age standardised rates have been presented to enable comparison of the practice networks without confounding by age.
- The alcohol specific conditions include the range of conditions that are causally implicated and have an alcohol attributable fraction of 1, as defined by Public Health England. [1]
- An analysis of trend and rate of change has been presented for the practice networks for the period 2006/07 to 2014/15. This has been compared to the CCG.
- An analysis by general practice has been presented by gender, often in the case of small numbers; this has been presented for the pooled years 2006/07 – 2014/15. This has been compared to the CCG.

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[1] Public Health England (2015) Local alcohol profiles for England 2015 user guide. http://www.lape.org.uk/downloads/LAPE%20User%20Guide_Final.pdf

Ashford CCG clinical network profile, February 2016

9.2.1 Alcohol Specific Hospital Admissions

For Rural, the age standardised rate of alcohol specific hospital admissions has shown an increasing trend between 2006/07 and 2014/15. The rate of change for Rural (-0.4, per 100,000 population) is decreasing compared to Ashford CCG (14.2).

The age standardised rate of alcohol-specific hospital admissions, per 100,000 population, persons, 2010/11 to 2014/15, persons, all age

Source: SUS, prepared by KPHO (LLY), 02/16

The rate of change for the age standardised rate of alcohol-specific hospital admissions, per 100,000 population, 2010/11 to 2014/15, persons, all age

Source: SUS, prepared by KPHO (LLY), 02/16

Ashford CCG clinical network profile, February 2016

The age standardised rate of alcohol-specific hospital admissions, per 100,000 population, 2011/11 to 2014/15, persons, all age

Source: SUS, prepared by KPHO (LLY), 02/16

A significantly higher age standardised rate of alcohol-specific hospital admissions in the under 75 population, in comparison to the CCG can be identified for Woodchurch Surgery and a significantly lower age standardised rate can be identified for Ivy Court Surgery.

| 10.   Social care

Social care data have been provided by the Adult Social Care department at Kent County Council. Ward level crude rates per 10,000 population have been calculated. For some indicators, either years or age bands have been pooled to increase reliability due to small numbers of people. For definitions of the indicators, see appendix B.

The tables below show the rate per 10,000 population for each indicator, and are classified as being significantly higher or lower than Kent using the following:

Significantly lower than Kent
Significantly higher than Kent

Social Services contact rate (per 10,000 population), for people aged under 65

Ward name	Care Home: Residential - Long Term placements, 2013-2015, Under 65	Direct Payments, 2013-2015, Under 65	Home Care, 2013-2015, Under 65	Support Services, 2013-2015, Under 65
Biddenden	0.0	31.4	5.2	14.0
Isle of Oxney	6.8	15.3	6.8	10.2
Rolvenden & Tenterden West	0.0	25.6	3.9	5.9
Romney Marsh	0.0	53.5	13.8	10.4
St Michaels	0.6	20.1	5.7	35.2
Tenterden North	0.0	32.8	9.4	28.1
Tenterden South	0.0	47.0	3.9	27.4
Weald Central	7.1	20.4	0.9	8.0
Weald South	43.7	33.2	3.5	11.4
Ashford CCG	**6.7**	**18.8**	**5.4**	**15.2**
Kent	**9.7**	**19.5**	**6.7**	**12.7**

Source: Social Care, KCC

As a CCG, Ashford has significantly lower rates of long term residential care home placements (6.7 per 10,000) and home care (5.4) users for people aged under 65 in 2013-2015 (pooled), than Kent (9.7 and 6.7 respectively). The rate of support services contacts per 10,000 population is significantly higher in Ashford CCG (15.2) than Kent (12.7).

Social Services contact rate (per 10,000 population), for people aged 65 and above

Ward name	Direct Payments, 2011-2015, 65+	Support Services, 2011-2015, 65+	Care Home: Nursing - Long Term Placements, 31/03/2015, 65+	Care Home: Residential - Long Term Placements, 31/03/2015, 65+	Home Care, 31/03/2015, 65+
Biddenden	25.6	0.0	0.0	0.0	109.4
Isle of Oxney	60.1	12.6	0.0	0.0	76.8
Rolvenden & Tenterden West	17.1	17.1	0.0	209.5	14.0
Romney Marsh	26.8	0.0	0.0	0.0	64.7
St Michaels	16.4	5.5	0.0	0.0	142.1
Tenterden North	19.4	0.0	0.0	0.0	96.0
Tenterden South	8.3	8.3	0.0	0.0	121.5
Weald Central	30.9	0.0	26.3	26.3	70.2
Weald South	103.3	4.3	0.0	6.9	89.8
Ashford CCG	**28.9**	**7.9**	**50.7**	**49.8**	**102.2**
Kent	**34.8**	**7.5**	**41.5**	**96.0**	**126.7**

Source: Social Care, KCC

Ashford CCG clinical network profile, February 2016

Ashford CCG has significantly lower rates of direct payments (28.9), long term residential care home placements (49.8), and home care (102.2) contacts for people aged 65 and above than Kent.

Social Services contact rate (per 10,000 population)

| Ward name	Enablement, 2011-2015, All ages	Meal Service, 2011-2015, All ages
Biddenden	3.9	0.8
Isle of Oxney	3.1	0.0
Rolvenden & Tenterden West	0.8	3.3
Romney Marsh	0.8	0.0
St Michaels	2.5	0.9
Tenterden North	8.9	1.8
Tenterden South	9.1	0.8
Weald Central	4.5	0.4
Weald South	3.8	1.1
Ashford CCG	**3.5**	**1.4**
Kent	**2.9**	**3.7**

Source: Social Care, KCC

Ashford CCG has a significantly higher enablement rate (3.5 per 10,000) than Kent (2.9), but a significantly lower rate of people using meal services (1.4 in Ashford CCG, 3.7 in Kent).
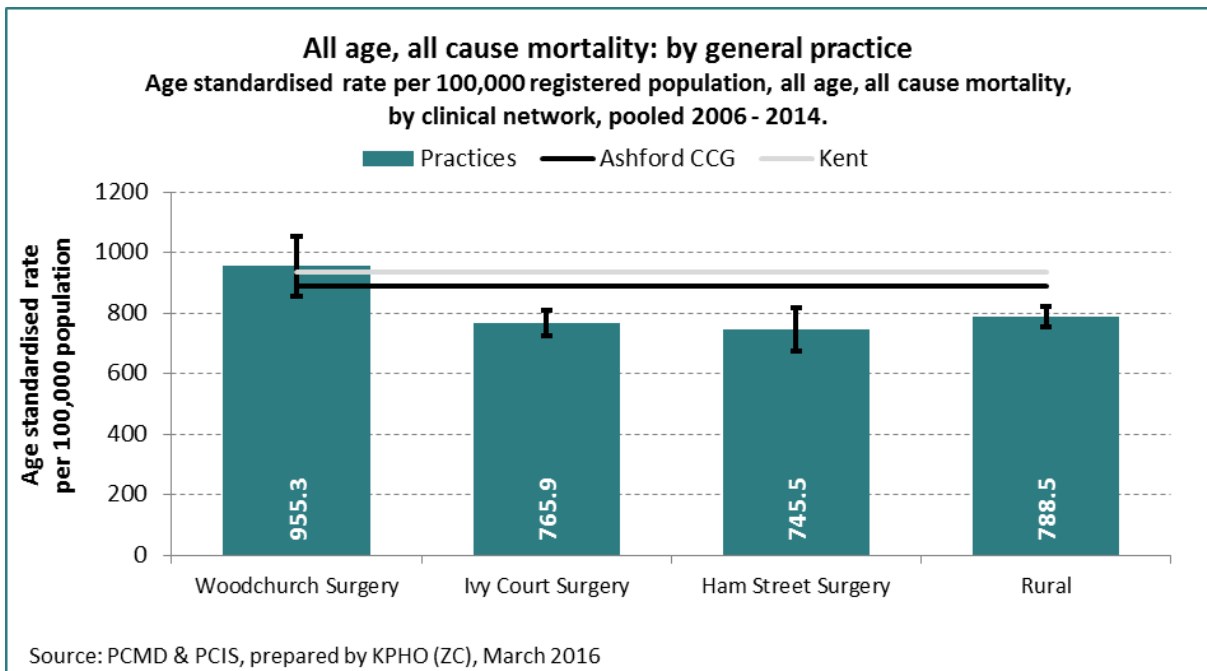
| 11.   Mortality

11.1 All Age, All-Cause Mortality

11.1.1 All age, all-cause mortality

Within the Rural clinical network within 2012-2014, the age standardised rate for all age all-cause mortality was 803.0 per 100,000 registered population. The trend has been stable within the Rural clinical network between 2006-2008 and 2012-2014. Whereas, the trend has been decreasing across Kent.
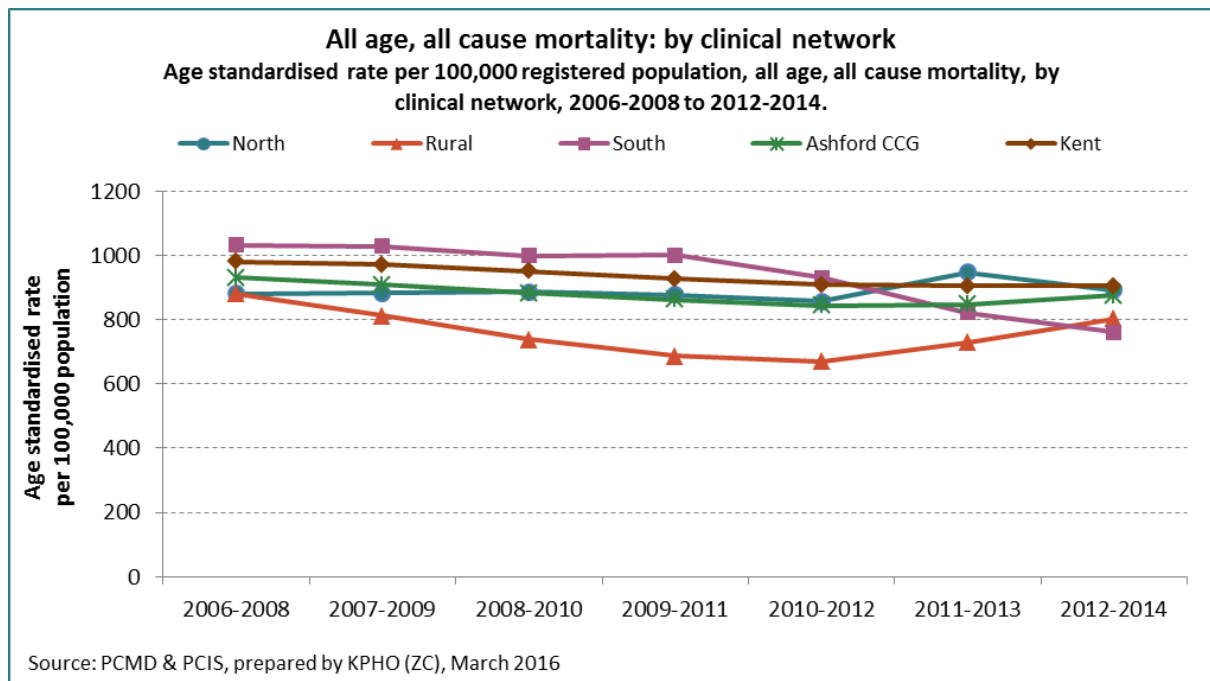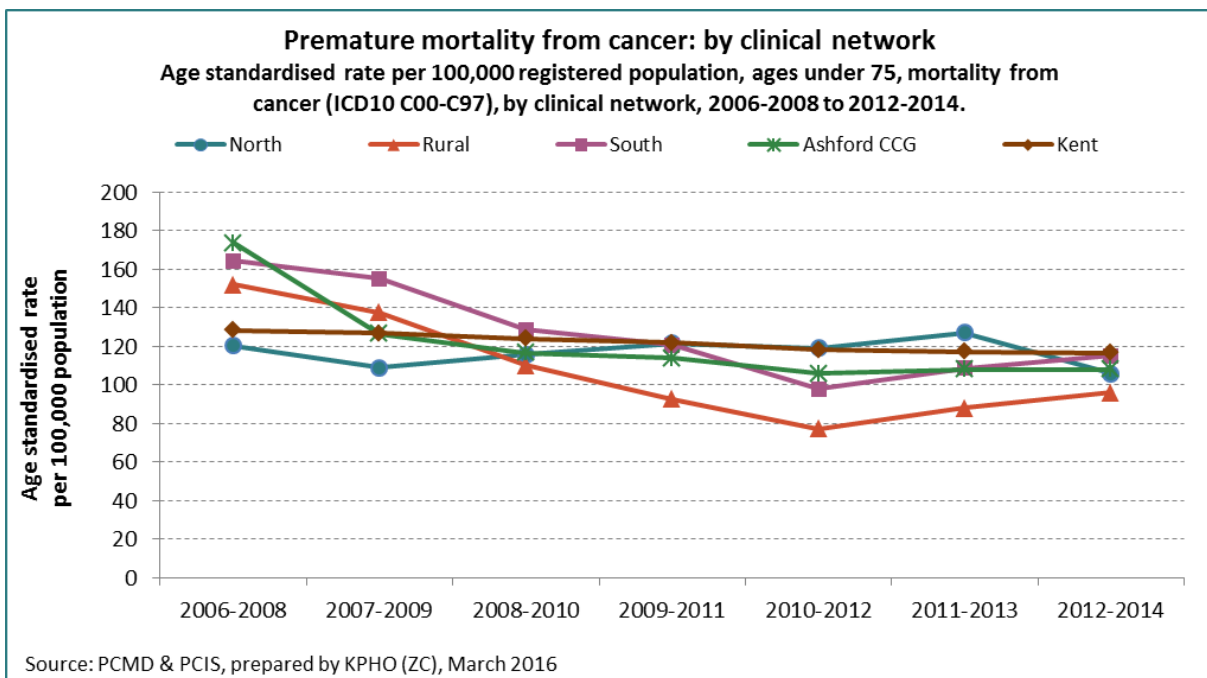

Within the Rural clinical network within 2006-2014, the age standardised rate for all age all-cause mortality for those registered at the Ivy Court Surgery and Ham Street Surgery was lower than the Kent average. The remaining practice was similar to Kent.
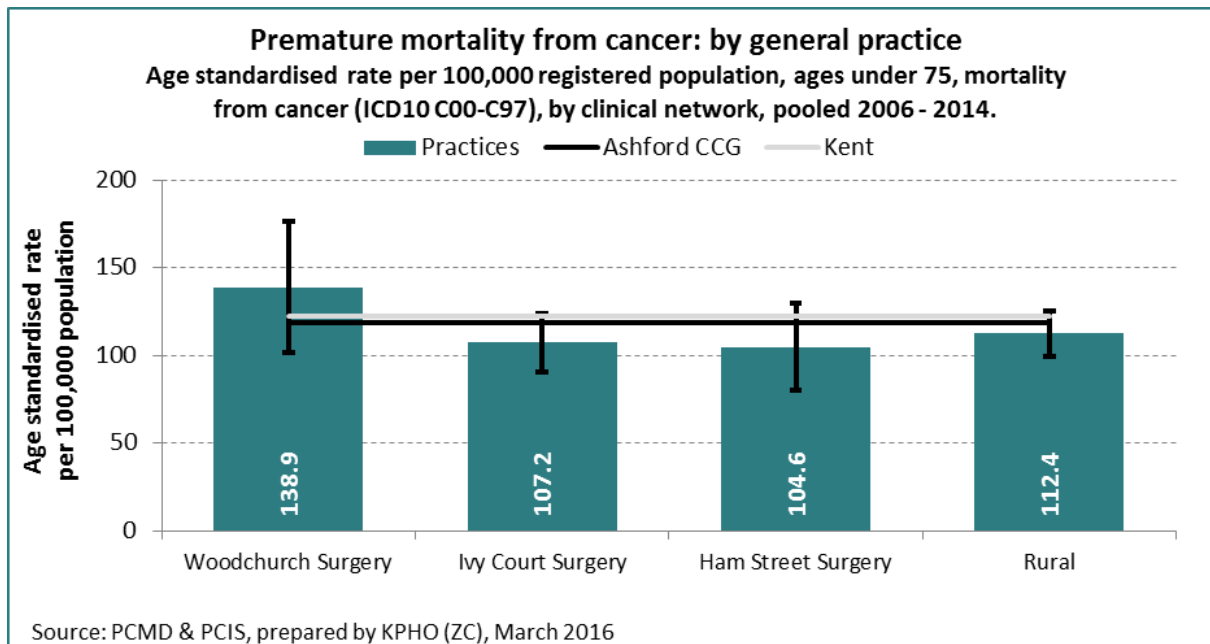
All age, all cause mortality: by general practice
Age standardised rate per 100,000 registered population, all age, all cause mortality, by clinical network, pooled 2006 - 2014.

Source: PCMD & PCIS, prepared by KPHO (ZC), March 2016

11.2 Premature Mortality: Cancer

11.2.1 Under 75 Cancer mortality

Within the Rural clinical network within 2012-2014, the age standardised rate for premature cancer mortality was 96.0 per 100,000 registered population and has decreased from 152.1 in 2006-2008. This has been decreasing at a rate of change that is greater than Kent.

Premature mortality from cancer: by clinical network
Age standardised rate per 100,000 registered population, ages under 75, mortality from cancer (ICD10 C00-C97), by clinical network, 2006-2008 to 2012-2014.
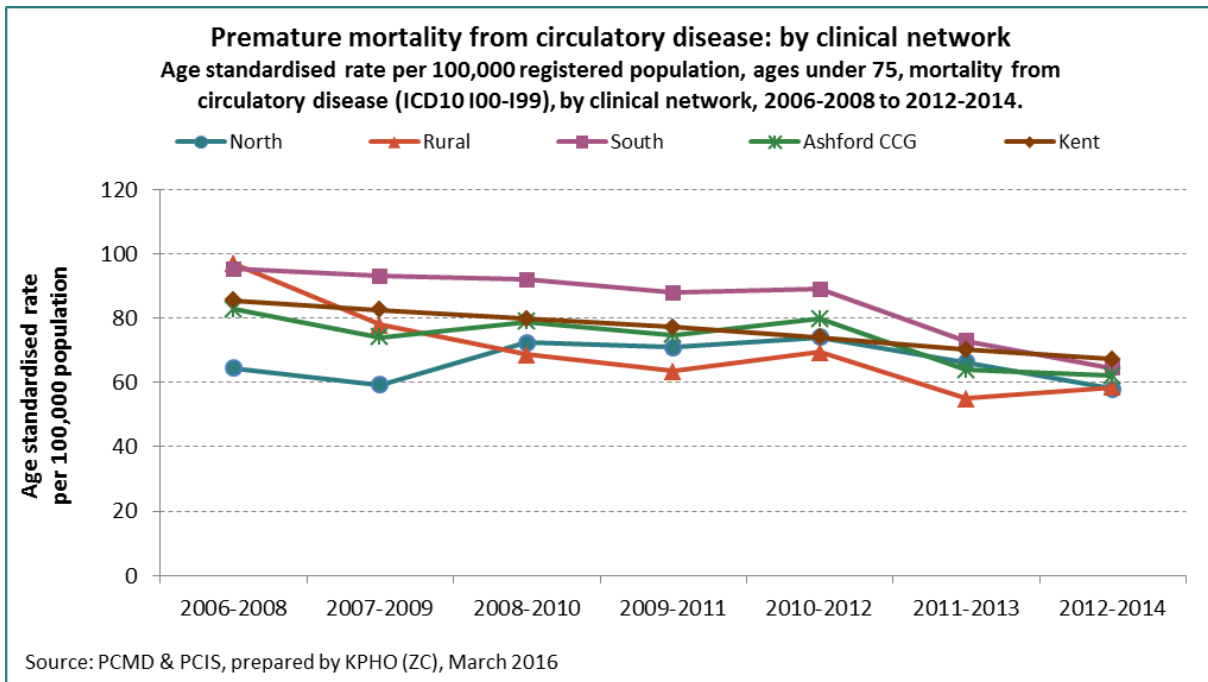
Source: PCMD & PCIS, prepared by KPHO (ZC), March 2016

Within the Rural clinical network within 2006-2014, the age standardised rate for premature cancer mortality was similar to Kent for all practices.

Premature mortality from cancer: by general practice
Age standardised rate per 100,000 registered population, ages under 75, mortality
from cancer (ICD10 C00-C97), by clinical network, pooled 2006 - 2014.

Source: PCMD & PCIS, prepared by KPHO (ZC), March 2016

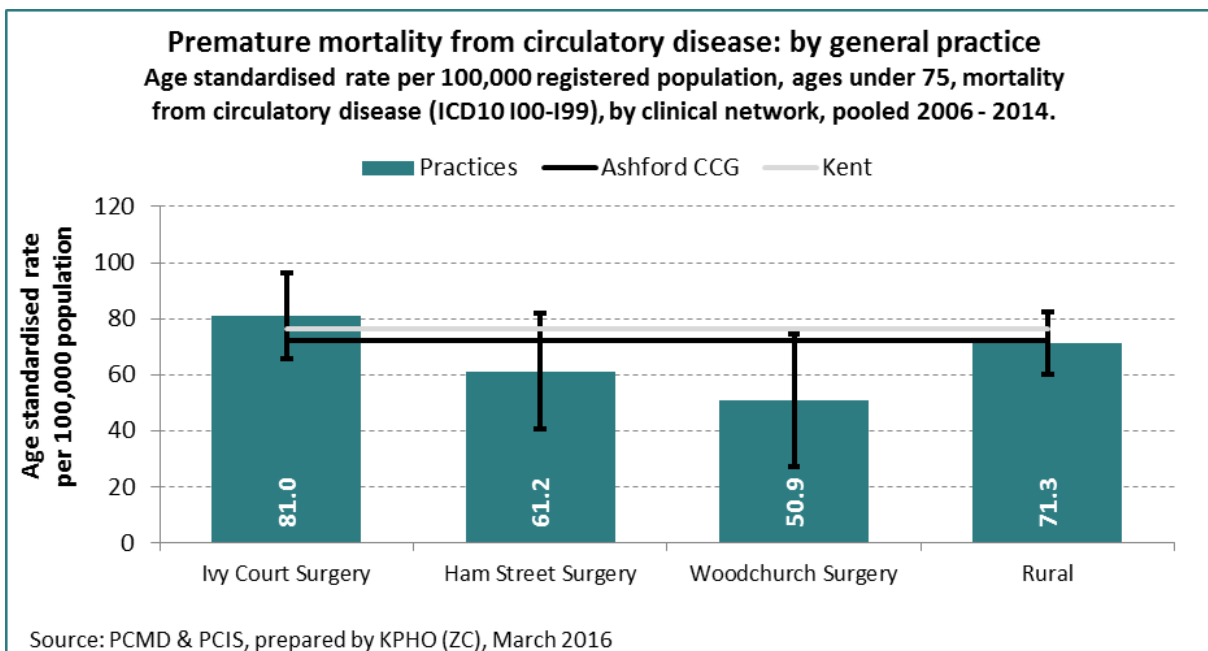Ashford CCG clinical network profile, February 2016

11.3 Premature mortality: Circulatory disease

11.3.1 Under 75 Circulatory disease mortality

Within the Rural clinical network within 2012-2014, the age standardised rate for premature circulatory mortality was 58.5 per 100,000 registered population and has decreased from 96.9 in 2006-2008. Similarly, the trend has been decreasing across Kent. But this is not a rate of change that is greater than Kent.

Premature mortality from circulatory disease: by clinical network
Age standardised rate per 100,000 registered population, ages under 75, mortality from circulatory disease (ICD10 I00-I99), by clinical network, 2006-2008 to 2012-2014.

Source: PCMD & PCIS, prepared by KPHO (ZC), March 2016

Within the Rural clinical network within 2006-2014, the age standardised rate for premature circulatory mortality was similar to Kent for all practices.

Premature mortality from circulatory disease: by general practice
Age standardised rate per 100,000 registered population, ages under 75, mortality from circulatory disease (ICD10 I00-I99), by clinical network, pooled 2006 - 2014.

Source: PCMD & PCIS, prepared by KPHO (ZC), March 2016

Ashford CCG clinical network profile, February 2016

| Appendix A: QOF clinical achievement indicators

- **Asthma 002**: AST002 The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or anytime after diagnosis
- **Asthma 003**: AST003 The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23
- **CHD 002**: CHD002   The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
- **CHD 006**: CHD006   The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin, NICE 2010 menu ID: NM07
- **COPD 003**: COPD003 The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months
- **COPD 004**: COPD004 The percentage of patients with COPD with a record of FEV1 in the preceding 12 months
- **Diabetes 003**: DM003 The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less, NICE 2010 menu ID: NM02
- **Diabetes 007**: DM007 The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months, NICE 2010 menu ID: NM14
- **Diabetes 009**: DM009 The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months
- **Diabetes 014**: DM014 The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register, NICE 2011 menu ID: NM27
- **Mental health 002**: MH002   The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate
- **Stroke and TIA 003**: STIA003 The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less

| Appendix B: Social care definitions

Long term residential care home placements:

Any placements in a residential bed at a registered care home which are long term ('permanent') and funded wholly or partly by the County Council, including on a temporary basis, or where the Council is administering payment on the service users behalf. This will exclude placements which are otherwise entirely funded by the service user or a third party (including other local authorities with social care responsibilities). It may include persons who formerly self-funded but whose assets have depleted and are now below the threshold for public funding.

Direct payments:

An individual is eligible for social care services and for an element of public funding. Payment of the public contribution (which may be for all or just part of the persons care package) is made direct to the individual who may then employ a personal assistant or buy care from an agency. The care may be delivered in their own home, a day care setting or a care home for planned short term respite care. Recent legislation will expand the use of direct payments for residential care provision.

Home care:

An individual is eligible for social care services (including respite breaks for a carer) and for an element of public funding. The persons need for care is likely to be ongoing and will be provided in their own home (domiciliary care). The Council will make arrangements for the care to be provided by an agency. It excludes equipment-only provision such as aids, adaptions and 'Telecare'.

Support services:

Services designed to maintain a person's independence in a community setting. Typically provided to persons with learning or mental health conditions, or younger adults with physical disabilities. While some element of personal care may be included, the service is primarily aimed at enabling the service recipient to function as independently as possible. This includes the 'Shared Lives' scheme and the Kent 'Supporting Independence' contracts.

Long term nursing care home placements:

Any placements in a nursing care bed at a registered care home which are long term ('permanent') and funded wholly or partly by the County Council, including on a temporary basis, or where the Council is administering payment on the service users behalf. This will exclude placements which are otherwise entirely funded by the service user or a third party (including the NHS and other local authorities with social care responsibilities). It may include persons who formerly self-funded but whose assets have depleted and are now below the threshold for public funding.

Enablement:

Short term planned interventions (typically up to three weeks) which aim to restore all or part of an individual's ability to live in a community setting or return home. This usually involves an element of rehabilitation and may follow a hospital admission or a deterioration in the persons physical or mental health. There is no charge to the service user. The service is provided by staff employed by the County Council, but similar 'intermediate care' services are available in care home settings and from NHS staff.

Meal services:

Delivery of meals arranged to the County Council to a person's own home. It may be ready to eat or frozen depending on the person's needs. The council funds delivery and the user pays the cost of the meal. In some localities, similar services may be provided by the voluntary sector, sometimes with the aid of grant funding by the County Council.