KENT PUBLIC HEALTH OBSERVATORY

Working Together to Keep Kent Healthy

Joint Strategic Needs Assessment Overview Report

August 2016

Integration, Partnerships and Prevention

Produced by

Abraham George: Public Health Consultant (Abraham.George@Kent.gov.uk)
Stephen Cochrane: Public health Specialist (Stephen.Cochrane@kent.gov.uk)
Emily Smith: Project Officer
Gillian Montgomery: Senior Administrative Officer: (Gillian.Montgomery@kent.gov.uk)
Correspondence to: Stephen.Cochrane@kent.gov.uk

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1. Kent Emerging Priorities

1.1 Cancer

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

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

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

In Kent the most common cancers in men are: prostate, colorectal and lung cancer; in women: breast, colorectal and lung cancer.

The highest incidence of cancer in Kent is seen in East Kent in the Dover and Thanet districts. Analysis of CCG QOF 2014/15 data suggests that the incidence of cancer is higher in East Kent than in North and West Kent.

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

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

Nationally it has been demonstrated that the route of diagnosis is associated with survival, with emergency presentations having low survival outcomes compared to other routes. For example between 2006 and 2013, one year survival was 97% for colorectal cancer patients diagnosed through screening, compared to 82% for patients diagnosed via urgent GP referral, and 49% for emergency presentations. For cervical cancer the figures are 99%, 83% and 45% respectively and for female breast cancer the figures are 100%, 97% and 53% respectively.

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

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

Both Thanet and Swale CCGs specifically mention cancer in their priorities.

Recommendations:

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

1.2 Demographics

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

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

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

1.3 Diabetes

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

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

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

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

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

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

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

Recommendations:

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

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

1.4 Growth

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

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

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

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

There are limitations on the data used for the GIF, but there is a clear need to refine the picture of health and care infrastructure to meet future growth in the next and future iterations of the GIF. The GIF authors cite whilst the findings of the GIF should be read with caution; they highlight a critical challenge in funding health and social care provision to meet future demand. In particular, the GIF has highlighted challenges in such provision in growth areas where the viability is more marginal.

1.5 Health Inequalities

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

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

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

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

Both South Kent Coast CCG and West Kent CCG specifically have health inequalities as a priority.

1.6 Healthy Weight

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

The prevalence of obesity varies across Kent, with the highest prevalence rates of adult obesity to be found in North Kent in Dartford and Swale CCGs and in East Kent, Shepway CCG. The highest rates in four to five year olds are found also found in these CCGs. The highest rates in 10 to 11 year olds are found in North Kent DGS CCG, and in East Kent in SKC CCG (Thanet and Dover). The Kent trend has not significantly changed in year R and year 6 for overweight, obesity and excess weight 2010-11 to 2014-15.

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

Healthy weight including obesity and physical activity is cited as a priority by both North Kent CCGs (DGS and Swale) and three East Kent CCGs – Canterbury and Coastal, South Kent Coast and Thanet.

Recommendations:

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

1.7 Mental Health

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

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

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

Mental health including suicides is mentioned by three East Kent CCGs – Canterbury and Coastal, South Kent Coast and Thanet.

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

- Commission local community asset mapping and development, and engagement, thereby enabling people to feel connected and in control.
- Continue commissioning psychological therapy.
- Ensure all front line professionals feel equipped to tackle emotional wellbeing and sign post to early help for community wellbeing.
- Improve social and community support via integrated work from troubled families, drug and alcohol services, mental health services and criminal justice systems.

1.8 Stroke

The recorded prevalence of stroke in Kent and Medway has increased from 1.56% in 2006/07 to 1.71% in 2013/14. The rate of change with each passing year was not significantly higher than England at 0.022%.

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

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

Thanet CCG specifically highlights stroke in their priorities.

Recommendations:

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

2. Key Highlights and Recommendations

The following section provides highlights and recommendations from the needs assessments that have been undertaken across Kent. From these needs assessments underlying themes and issues have been identified as factors most important for Kent to reduce health inequalities, improve health and wellbeing and to deliver improved health and social care outcomes.

2.1 Starting Well

2.1.1 Children in Care

In March 2015 there were 1,870 children in care, resident in Kent, at a rate of 57 per 10,000 children aged under 18 years. This rate has been stable for the previous four years. The rate in Kent is higher than the rate for South East England as a whole but similar to that of England.

There were 970 unaccompanied asylum seeking children as of the end of October 2015, more than three times the number than at the beginning of 2015. The majority of this group are from Eritrea and Afghanistan and aged 16 and 17 years old. The physical and mental health needs of this group are likely to be complex given the experiences they may have had in their home countries and on their journey to the UK. Initial health assessments are undertaken with the young people after they arrive and efforts are made to complete immunisation schedules and screen for infectious diseases. Work is currently being undertaken to further understand the health needs of this population, in particular mental health, to ensure that there is provision in place to meet these needs.

2.1.2 Children and Adolescent Mental Health Services

Mental health problems in children are associated with educational failure, family disruption, disability, offending and antisocial behaviour, which places demands on social services, schools and the youth justice system.

In Kent:

- Fewer numbers of children are being seen in Tier 2 services
- Higher levels of self-harm and psychosis are seen in Tier 2 and Tier 3 services
- Slightly fewer males and slightly more females access services than would be expected nationally
- An under representation of conduct and hyperkinetic disorders and fewer younger boys are being seen than expected nationally
- An under representation of African and Caribbean children and an over representation of Asian and mixed race children, which varies across different providers i.e. NHS West Kent and Kent and Medway Partnership Trust (KMPT)
- More children with learning disabilities access services
- looked after children and young offenders are under represented both according to local need and to national comparison
- Children and young people aged 10-14 years accessing services more than at 15-18 years
- There is a gap in transition services from CAMHS to adult services.

2.1.2.1 The Community CAMHS Model

A community model has been developed for Kent which recognises that although vulnerable children may need CAMHS at some point, all partner services need to be responsive and able to cope with a child's emotional needs. For example if a child is bullied severely at school and in distress, rather than referring to CAMHS, the school, with support from CAMHS, should be able to help the child. For the community model to be effective all agencies need to agree and sign up to a common way of working, and refer to Early Help services. This will ensure that a child gets the appropriate level of service and intervention when they require it.

Recommendations:

- Focus work on vulnerable groups particularly CAMHS Tier 2 and Tier 3 support for young offenders and looked after children
- Children who have mothers with mental health problems and children with parents' dependant on alcohol is a high impact area that needs addressing. This would be achieved through working more closely with adult services to identify, risk assess and intervene in family support and provide good Tier 2 type support for those children at risk
- Improve services for adolescent emotional health and equip parents and front line professionals and peers to enable conversations and trusted relationships so that adequate support can be given for young people who self-harm
- Address the issues and risks inherent in cyber culture.

2.1.3 Dental Health in Children

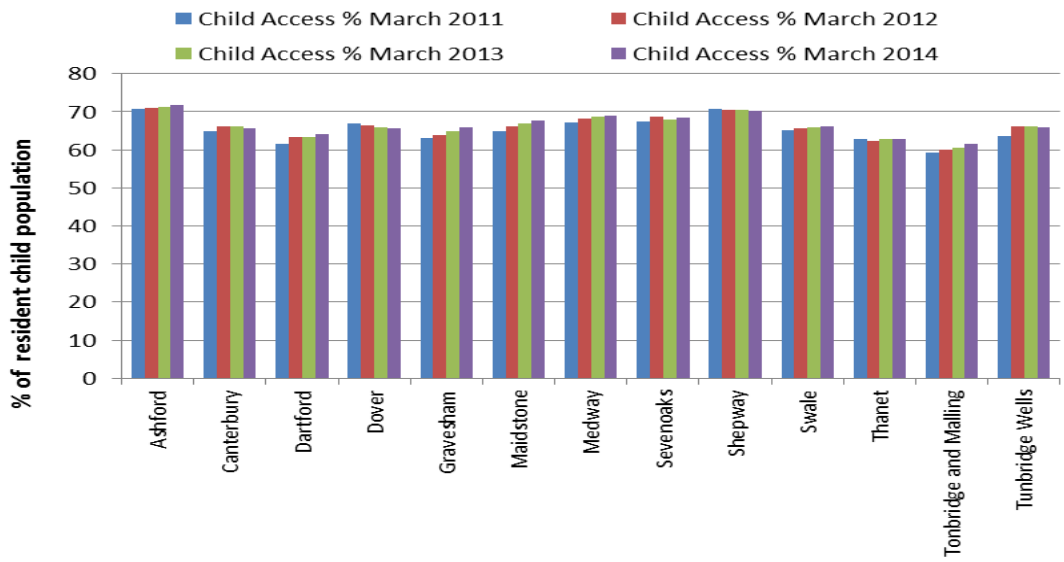
Surveys carried out in special support schools in 2014 indicate that decay severity in five-year olds in Kent (47%) is higher than in the South East (33%). Where decay is present, the average number of teeth decayed in Kent five year olds is higher (four) compared to the South East (three).

Decay severity in 12 year olds surveyed (2014) in special support schools is slightly higher in Kent (51%) than in the South East (50%). The average number of teeth decayed (four) is higher than in the South East and England where it is two for each.

Extraction data for 2012-13 and 2013-14 indicate that there are higher levels of extractions in 0-19 year olds in the districts of: Shepway (9%), Dover (7%), Ashford (5%) and Thanet (4%) than in the South East (3%). Further inspection of the data reveals that this is largely due to extraction increases in the five to nine year old age group.

There exists geographical and historical (based on March 2011 to March 2014 data) inequality in the uptake of primary care dental services by children in Kent's districts. At district level, uptake varies from 70-71% in Ashford to 59-61% in Tonbridge and Malling. Kent and Medway's uptake averages are 67-68% for the same period.

Figure 1: Child dental access by district March 2011 to March 2014



Source: Business Service Authority

Recommendations

- Gain broader understanding of the barriers that exist in special support schools achieving optimum oral health for children and ensure tailored oral health training/promotion addresses any issues found.
- Promote early and continued engagement of children with dental services and particularly target areas where there are higher levels of extractions.
- Employ the principles of Making Every Contact Count to ensure parents receive consistent messages about how to prevent oral health disease, how to maintain good oral health and how to access a dental practice.

2.1.4 Maternal Health

The number of live births in Kent has fluctuated over the past three years for which data is available with an average of just over 17,400 births per year. There has been no distinct upward or downward trend.

Kent has a lower infant mortality rate than both the England and South East average. Canterbury has the highest infant mortality rate of all Kent districts and Maidstone the lowest. Canterbury and Dover districts have infant mortality rates higher than the South East average but lower than the national average.

Swale CCG has the highest percentage of mothers smoking at the time of delivery at just over 20%. South Kent Coast, Swale and Thanet CCGs all have higher smoking rates at delivery than the Kent and Medway average. The percentage of women smoking at the time of delivery is lowest in West Kent CCG at just under 10%.

In Kent, 71.3% of women breastfeed their babies in the first 48 hours after delivery, lower than the England and South East average.

2.1.5 Teenage Pregnancy

Overall, Kent has a lower teenage pregnancy rate that the national average. Thanet and Dover had the highest teenage conception rates in 2013; the lowest rates were in Tunbridge Wells and Sevenoaks. Thanet, Dover, Gravesham, Swale and Shepway all had teenage conception rates above the national average.

Since 2008 the rate in Kent has fallen from 42.1 to 22.9 conceptions per 1,000 (females aged 15-17). There are significant differences in progress to reduce rates across the districts of Kent, with Shepway having achieved the best reduction of 59%, and Tonbridge and Malling having shown the lowest decrease of 31.1%.

2.2 Living Well

2.2.1 Adults with Learning Difficulties

As of 2014-15, Kent has 6,405 persons identified with learning disabilities in the Quality and Outcomes Framework (QOF). The rate is 0.42%, slightly below that of England's average of 0.44%. Within Kent, the highest prevalence of learning disabilities can be identified within South Kent Coast CCG at 0.66%.

2.2.1.1 Population Changes

Factors that could lead to a change in the number of people with learning disabilities include changes in the future size and composition of the Kent population, and potential changes in the incidence and prevalence of learning disabilities. There is expected to be a steady but consistent increase in the number of people with a LD across all districts and CCG areas between 2014 and 2030, with approximately 5,216 persons with moderate or severe learning disability within the districts of Kent in 2030. In Kent, it is predicted that the number of people aged 18–64 years to have a learning disability will rise from 21,522 in 2015 to 22,722 in 2030.

Recommendations:

The LD needs assessment identifies gaps in current services and makes a set of recommendations to improve service accessibility for improved outcomes. The key recommendations are:

- To provide parenting support to parents with a LD by working with children centres to deliver public health messages in an easy read format.
- Explore the opportunities available to enabling young people and adults with a LD to have greater control over their lives through the Becoming an Adult Partnership group.
- Deliver public health messages in easy read format on all campaigns aimed at people with learning disabilities (e.g. campaigns on the use of alcohol and smoking in pregnancy to reduce risk of premature births and low birth weight, bowl screening and breast screening campaigns).

2.2.2 Antimicrobial Resistance

Existing antibiotics are used to treat an ever greater variety of infections and infectious diseases. Antibiotic prescribing and antibiotic resistance are inextricably linked, and overuse and incorrect use of antibiotics are major drivers of resistance. Antibiotic consumption is a major driver for the development of antibiotic resistance in bacteria

2.2.2.1 Antibiotic Prescribing

Analysis by *GPonline* of the Health and Social Care Information Centre's (HSCIC's) latest prescribing figures, extract from ePACT (service provided by NHS Prescription Services) covering the first quarter of the 2015-16 financial year (April-June), show that CCGs spent a combined total of over £427m on antibiotic prescriptions.

When taking into account the number of GP registered patients at each CCG and the amount incurred by each CCG on antibacterial drugs, the average amount spent per patient varies hugely, ranging from £4.19 in West London CCG to £10.00 at Knowsley CCG, an over two-fold difference. Kent CCGs spent between £7.00 and £8.32 per patient during the quarter. (See Table 1 below.)

The national aim is to reduce levels of prescribing back to that seen in 2010. This will be achieved by using antibiotic stewardship for all healthcare prescribers and professionals as the primary method to achieve the outcome. Kent CCG's medicine management teams in conjunction with the local acute trust are leading the programmes.

Specific recommendations on better prescribing by GPs include:

- no prescribing of antibiotics for simple coughs and colds
- no prescribing of antibiotics for viral sore throats
- limiting prescribing for uncomplicated cystitis to a three day course of antibiotics.

All Kent CCGs report on antibiotic prescribing through their quality committees.

East and West Kent CCGs have an antibiotic prescribing group and an antimicrobial stewardship group. North Kent CCGs have yet to set up either group.

Table 1: Kent CCG Prescribing Spend for the First Quarter of the 2015-16 Financial Year (April-June)

CCG: NHS Ashford **Spending per patient:** £7.65 **Amount spent:** £970,174	**CCG:** NHS Canterbury and Coastal **Spending per patient:** £8.28 **Amount spent:** £1,787,315
CCG: NHS Dartford, Gravesham and Swanley **Spending per patient:** £8.04 **Amount spent:** £2,086,669	**CCG:** NHS South Kent Coast **Spending per patient:** £8.32 **Amount spent:** £1,662,309
CCG: NHS Swale **Spending per patient:** £7.00	**CCG:** NHS Thanet **Spending per patient:** £7.70

Amount spent: £761,275	**Amount spent:** £1,103,781
CCG: NHS West Kent **Spending per patient:** £7.64 **Amount spent:** £3,649,054	

The issue of Kent patients being prescribed an antibiotic by their GP for coughs and colds is being addressed using the national education campaigns for patients and local prescribers training programmes, audits and by local monitoring of prescribing data.

Other initiatives are also being used including East Kent hospitals using an app to disseminate their antibiotic formulary with very promising results. This app is now being explored for use in the community and particularly for GPs. South Kent Coast and Thanet CCGs will be uploading their formulary onto this app.

Clinical recommendations:

- Continue with the antibiotic stewardship programme in East & West Kent CCGs.
- North Kent CCGs should introduce the antimicrobial stewardship
- Ensure that all the surveillance prescribing and patient awareness evidence and outcomes are reviewed, evaluated and actioned by all of Kent health professionals
- Any new evidence is evaluated, agreed, actioned and then audited as required
- Ensure the multidisciplinary antimicrobial stewardship groups continue and that North Kent convenes as soon as possible
- Kent requires one antibiotic formulary and all the parties agreed to it
- All antibiotic prescribers, particularly veterinary, follow the principles of reducing antibiotics prescribing to the level of 2010
- The sepsis programme should be followed by Kent CCGs.

2.2.3 Behaviour Change

Chronic diseases, such as cardiovascular disease, cancer, respiratory disease and diabetes, can be closely linked to behaviours and lifestyle risk factors which can be changed by an individual. People in the poorest communities are more likely than others to exhibit at least one and often several of these risk factors. Changing one or more of the behaviours involved will help people significantly reduce their risk of illness and also help reduce health inequalities. Additionally, it will lead to a reduction in premature deaths and disability over time and the associated costs in terms of healthcare, social care and welfare benefits, so leading to long term cost savings.

The use of evidence based principles and behaviour change techniques should be promoted. These can be found in well conducted evaluation studies and randomised controlled trials with minimal bias.

Recommendation:

- Based on best quality evidence, it is recommended that principles and behaviour change techniques should be promoted.

2.2.4 Cancer

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

The prevalence of cancer has increased due to a combination of an increasing average life expectancy of the population and an increased occurrence of risk factors for cancer (e.g. obesity). Survival rates have been improved due to better diagnosis and treatment. It is estimated that by 2030 the number of people living with and beyond cancer will increase form 40,000 in 2010 to 60-80,000 in 2030.

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

The most common cancers in men in Kent are: prostate, colorectal and lung cancer. The most common cancers in women in Kent are: breast, colorectal and lung cancer.

The highest incidence of cancer in Kent is seen in the Dover and Thanet districts. Analysis of former PCT data between 2007-08 and 2008-10 suggest that the incidence of cancer is higher in Eastern and Coastal Kent than in West Kent.

The trend in one year survival after cancer diagnosis is upward, and is 69% in Kent overall, which is consistent with the England average. However, lower one year survival is noted in Thanet and Swale.

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

Nationally it has been demonstrated that the route of diagnosis is associated with survival. For example between 2006-10 one year survival was 98% for cancer patients diagnosed through screening, compared to 83% for patients diagnosed via urgent GP referral, and 49% for emergency presentations.

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

Recommendations:

- Prevention of cancer and subsequent death involves both reduction in risk factors for cancer, such as smoking and obesity and early detection of pre-cancerous

changes through screening programmes. Improving uptake of screening programmes should be a priority.

- Risk factors for cancer include the male sex and lower socioeconomic status. These risk groups should be targeted to reduce cancer incidence.
- More work is needed to understand the significance of the high rate of urgent GP referrals to cancer services in East Kent.

2.2.5 Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease (COPD) includes two main diseases: bronchitis and emphysema. Asthma may also be included within the term COPD if there is some degree of chronic airway obstruction.

COPD not only affects the lungs but has extra pulmonary effects such as muscle wasting and weight loss, pulmonary hypertension, or pulmonale (enlargement of the right side of the heart), anxiety and depression.

The most important cause of COPD is smoking, but past exposures to fumes, chemicals and dusts at work will have also contributed to causing many currently occurring cases. Reports by respiratory and occupational physicians (British Thoracic Society and the Society of Occupational Medicine - Surveillance of work-related and occupational respiratory disease THOR-SWORD) and assessments for Industrial Injuries Disablement Benefit (IIDB) greatly understate the annual number of new cases of work related COPD.

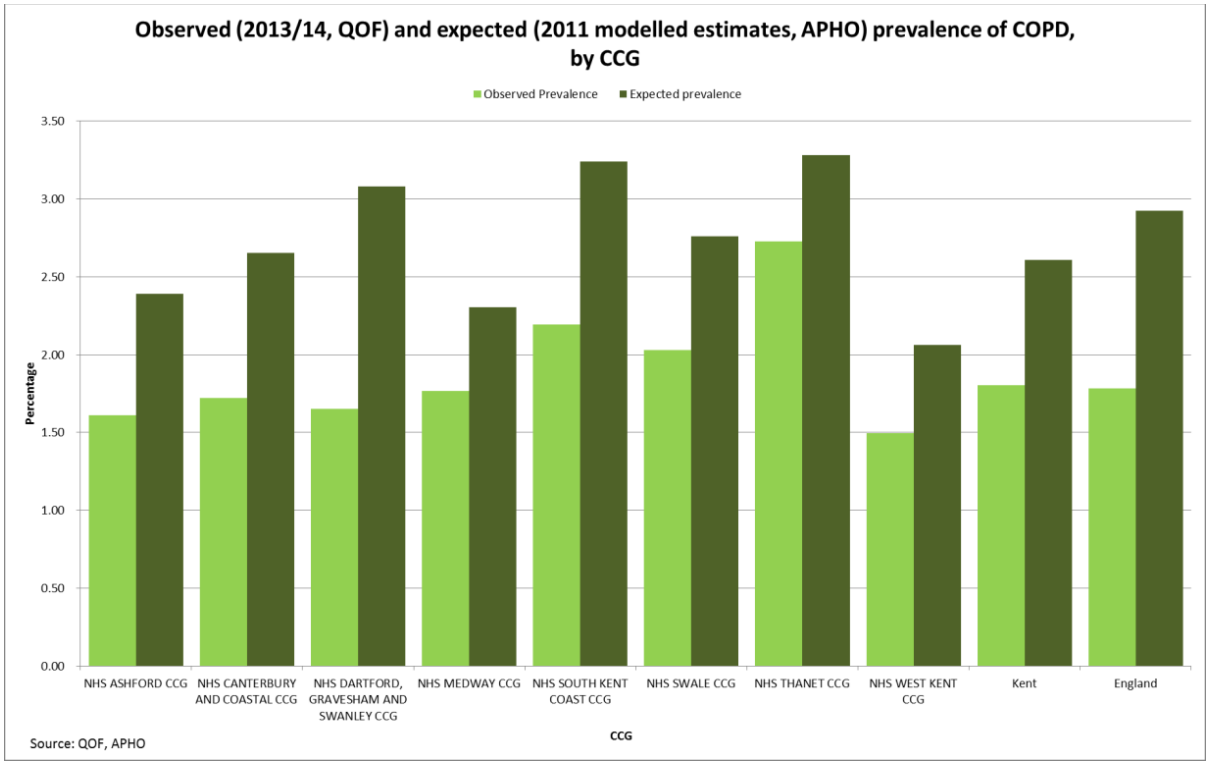
Other research suggests that about 15% of COPD can be attributed to workplace exposures.

2.2.5.1 Prevalence

The clinical commissioning groups (CCGs) that have the worst COPD rates in Kent are Thanet, South Kent Coast and Swale. Thanet has the worst rate in the South of England, with a rising trend in all these areas. All other CCGs in Kent have rates that are better than the South of England average.

However, when the expected prevalence is modelled, a slightly different emphasis can be put on the data. Thanet CCG rates best represent what is thought to be the actual prevalence, whilst Dartford, Gravesham and Swanley CCG appear to have a large number of patients who are undiagnosed.

Figure 2: Observed (2013/14, QOF) and expected (2011 modelled estimates, APHO) prevalence of COPD, by CCG



Recommendations:

- Commissioners need a higher priority for targeted prevention, particularly smoke free interventions and improvement in smoking cessation outcomes particularly in areas of higher deprivation.
- Opportunist systematic case finding and better recognition of signs and symptoms by health care professionals is needed, especially those in primary care as well as better communication about signs and systems to the general population.
- Consideration should be given to targeting specific occupational groups to assess their risks.
- Commissioners need to ensure that integrated programmes with access to care from a multidisciplinary team are accessible for all of those with COPD.
- Embedded personalised care and support for self-management for people with COPD (and their carers) should be provided, and patients should receive disease specific education and training to become active partners in a systematic approach to care planning and management
- Attention should be paid to the outcomes of the latest COPD audits to inform care management. (The final reports are expected in 2016.)

2.2.6 Community Pharmacies

All health and wellbeing boards (HWB) in England are required to publish a Pharmaceutical Needs Assessment (PNA) every three years. These will be used to determine future approval of applications for new pharmaceutical and dispensing services.

Kent County Council HWB published their PNA in March 2015. The assessment is divided into the seven CCG areas and can be found at http://www.kpho.org.uk/__data/assets/pdf_file/0009/43578/Kent-Pharmaceutical-Needs-Assessment-Final-version-March-2015.pdf

In Kent, pharmaceutical services are provided by 277 community pharmacies and 54 dispensing practices, of which 33 are "100 hours" pharmacies situated relatively evenly across the seven CCG areas.

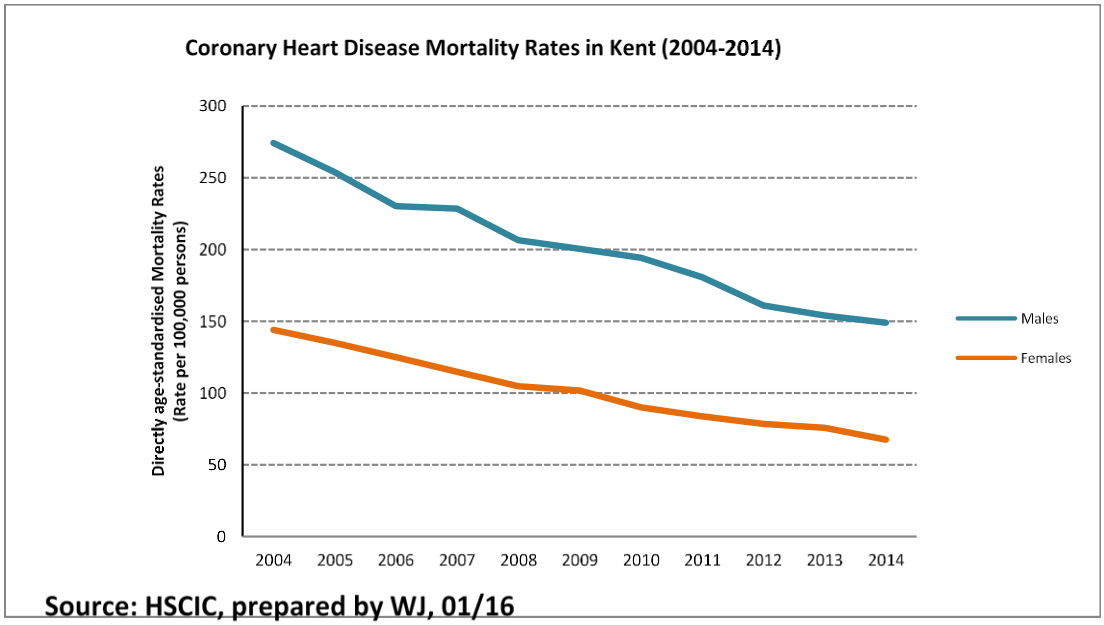
Key findings and recommendations:

- Overall there is good pharmaceutical service provision in the majority of Kent.
- Where the area is rural, there are enough dispensing practices to provide basic dispensing pharmaceutical services to the rural population.
- There are proposed major housing developments across Kent, the main ones being Chilmington Green near Ashford and Ebbsfleet Garden City. This will mean that these areas will need to be reviewed on a regular basis to identify any increases in pharmaceutical need.
- The proposed Paramount leisure site plans in North Kent should be reviewed regularly to identify whether visitors and staff will have increased health needs including pharmaceutical.
- The current provision of "standard 40 hour" pharmacies should be maintained especially in rural villages and areas such as Romney Marsh.
- The current provision of '100 hour' pharmacies should be maintained.
- The Health and Wellbeing Board has the responsibility of publishing supplementary statements when the pharmaceutical need and services to an area change significantly. It is proposed that these are issued every six months by NHS England (a member of the board) as they hold all the relevant data. They will be published on the council website alongside the PNA.

2.2.7 Coronary Heart Disease

Modifiable risk factors for coronary heart disease include high blood pressure, high cholesterol, physical inactivity, poor diet, excess weight, smoking, alcohol, and diabetes blood sugar control. As such, public health interventions have a significant role in tackling coronary heart disease (CHD) in Kent. The Health Checks programme is a systematic way of identifying and reducing cardiovascular risk. As per previous estimates, overall CHD prevalence in Kent still appears to be increasing in line with national trends, largely due to higher reporting and case finding rates.

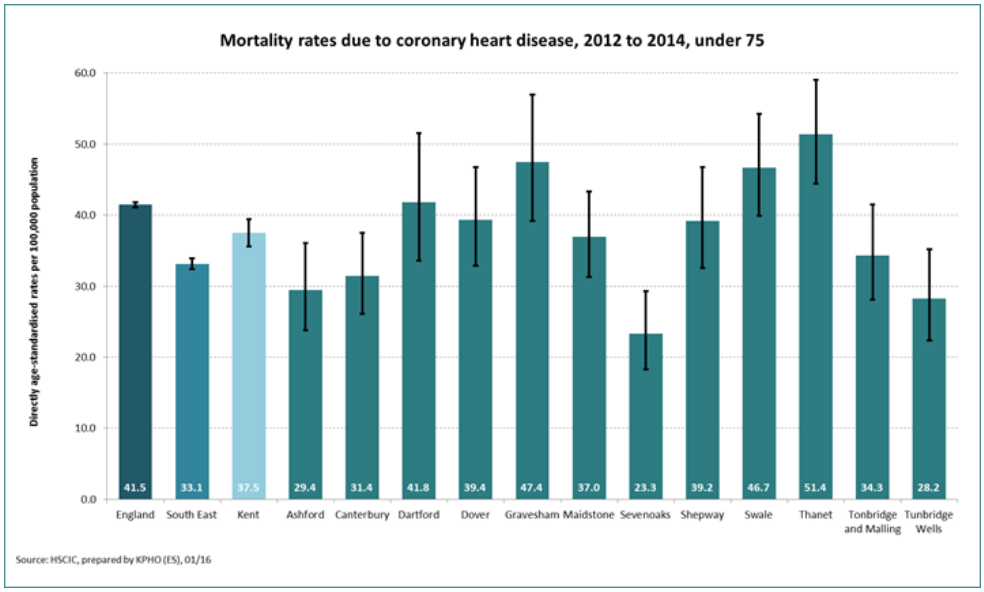
Figure 3: Coronary Heart Disease Mortality Rates in Kent (2004-2014)



Males are at greater risk of coronary heart disease than females. In contrast to CHD prevalence, CHD mortality rates are reducing across Kent (as per the national trend), largely due to greater use of revascularisation therapy. Revascularisation can be done via percutaneous coronary intervention (PCI) or coronary artery bypass graft surgery (CABG). In 2014-15, there were 1,735 cases of PCI to 519 cases of CABG a ratio of over 3:1. This ratio has been stable over the last few years. Also the ratio of Kent residents receiving PCI in Kent itself, rather than London, has also been stable over the last few years as shown in Figure 4.

Deprivation is strongly linked to CHD and lower life expectancy. The data in Figure 4 shows that districts with higher rates of deprivation, such as Thanet district, have a higher coronary heart disease mortality rate (51.4), than more affluent areas of Kent, such as Tonbridge and Malling (34.3). In particular, premature mortality due to cardiovascular disease (deaths occurring under age 75) is strongly associated with deprivation. By increasing the awareness of risk factors and tackling them as part of our joint Health and Wellbeing Strategy we should be able to reduce CVD health events and reduce health inequalities. An integrated commissioning approach is required to reduce the burden and impact of coronary heart disease in the population. This links with work around risk stratification for the "Year of Care" work done by Kent County Council, a data driven approach to better commissioning for long term multiple morbidity in Kent.

Figure 4: Mortality rates due to coronary heart disease, 2012 to 2014, under 75



Recommendations**:**

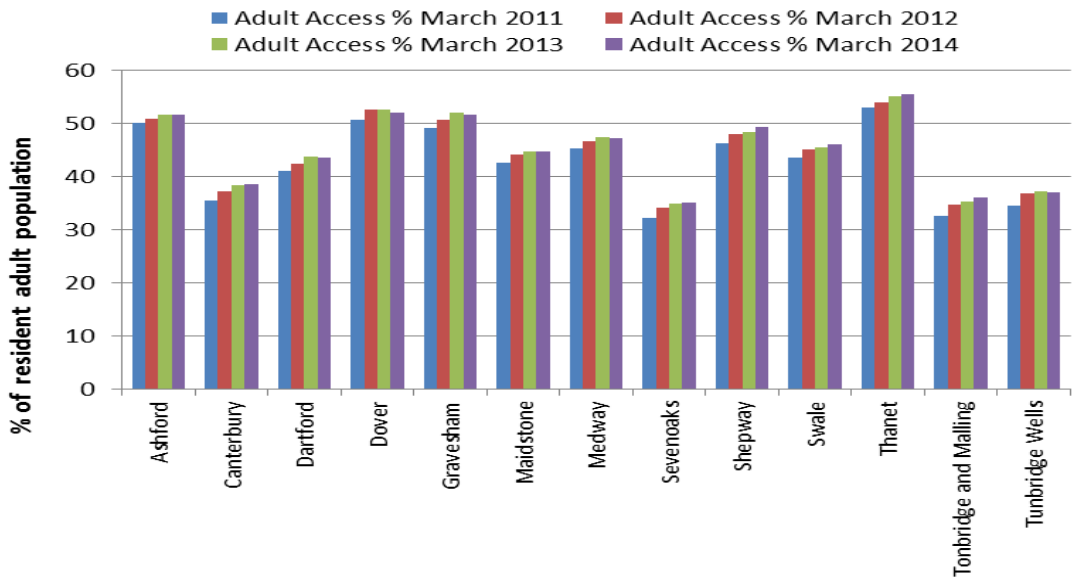
- Public health commissioners should continue to commission services that promote healthier lifestyles, smoking cessation, and cholesterol and hypertension management to reduce CHD multiple modifiable risk factors.
- Clinicians should continue to report higher case findings.
- Commissioners should continue to commission revascularisation therapy.
- Service provision should focus upon the significant locality inequalities that exist in CHD mortality across Kent, which is closely associated with deprivation.
- The practice of integrated commissioning and risk stratification will allow for greater CHD identification and risk management in susceptible individuals.

2.2.8 Dental Health in Adults

In the South East, 28% of adults visit the dentist “only with trouble” and 25% of adults visit the dentist less often now than five years ago. In addition, 3% of older adults have very severe gum disease suggesting historical, ineffective home oral hygiene knowledge/practice and infrequent professional removal of plaque/calculus.

Adult engagement rates with clinical services vary across districts from 52-54% in Thanet to 36 to 38% in Canterbury in the period March 2011 to March 2014. The rate of engagement for Kent and Medway for the same period is 50-51%. The reasons for this variance may be about patient choice or an inability to gain access to services.

Figure 5: Numbers of Adults Seen at NHS Dentists as a Percentage of the Adult Population



Source: Business Service Authority (BSA)

Recommendations:

- Work with partners, providers and stakeholders to gain a better understanding of the dental health needs of older adults in order to better target oral health promotion.
- Ensure oral health promotion features in public health communication plans and strategies and that there is clear information available on accessing NHS dental services.
- Investigate reasons for the varying levels of uptake of dental services in Kent.

2.2.9 Diabetes

In 2014, the prevalence of diabetes in the adult population in England was 6.2% (2,814,004 people). By 2025, it is estimated that five million people will have diabetes in the UK.

It is estimated that 10% of all adults with diabetes in the UK have Type 1 diabetes which generally appears before 40 years of age. The estimated rate of diabetes in children under the age of 15 is 187.7 per 100,000. The estimated number of children with diabetes in the UK is 31,500, of which 95.1% are Type 1. Boys are more likely to have Type 1 diabetes than girls. There is a genetic link with Type 1 diabetes.

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

The National Diabetes Audit shows that there is a 138.8% increased risk of angina, a 94.2% increased risk of myocardial infarction (heart attack), a 126.2% increased risk of heart failure and a 62.5% increased risk of stroke. Approximately 20% of hospital admissions for heart failure, heart attack and stroke are in people with diabetes. About three in four people with diabetes will develop kidney disease during their lifetime.

Diabetes is the leading cause of preventable sight loss in people of working age in the UK. People with diabetes are estimated to be up to 30 times more likely to have an amputation compared with the general population.

People with diabetes are twice as likely to suffer an episode of depression. They are also likely to be depressed longer than the general population. People with depression are very likely to develop diabetes.

Babies of women with diabetes are five times as likely to be stillborn, three times as likely to die in their first months of life and three to six times as likely to have a major congenital anomaly.

Women with diabetes are five times more likely to have a preterm baby than women without diabetes and three times more likely to have a Caesarean section delivery. They are also twice as likely to have a baby weighing more than 4kg.

People with Type 2 diabetes are at a 1.5–2.5 fold increased risk of dementia and are twice as likely to be admitted to hospital.

The National Diabetes Audit published on 26 January 2016 is currently being analysed for more local outcomes but the participation rates are quite low in Kent clinical commissioning groups (CCGs). This information by CCG will be included in the forthcoming update of the main Diabetes JSNA chapter.

The NHS 5 Year Plan has put much emphasis on prevention and the Government has prioritised the prevention of diabetes and South East CCGs were successful in a joint bid to implement the National Diabetes Prevention Programme locally. This aims to identify people with poor levels of glycaemic control before they convert to diabetes and to refer them onto programmes tailored to their needs, but similar to community weight management programmes.

The data in Table 2 shows prevalence of Type 2 diabetes and change over the preceding year. Thanet and West Kent CCGs have experienced a drop in the rate of diabetes diagnosis; neither CCG can account for this but are investigating.

Table 2: Prevalence of Diabetes Mellitus in 17+ Population by Kent CCGs

CCG	Register	Prevalence	Change from previous year
NHS ASHFORD CCG	6,142	6.17	1.51
NHS CANTERBURY AND COASTAL CCG	10,467	5.86	1.93
NHS DARTFORD, GRAVESHAM AND SWANLEY CCG	12,831	6.33	1.03
NHS SOUTH KENT COAST CCG	15,701	6.86	2.95
NHS SWALE CCG	11,408	7.07	2.50
NHS THANET CCG	8,180	7.12	-1.24
NHS WEST KENT CCG	20,665	5.48	-0.50

Recommendations:

- All parts of the system should take action to ensure that processes are in place to guarantee that the population is advised about how to change behaviour to achieve a healthier diet and take more physical activity.
- Primary care should keep updated records of people's level of risk and create a recall system which will allow patients to be contacted and invited for regular reviews; in Kent this will be expected to be implemented through the National Diabetes Prevention Programme from 2016.
- Effective systems should be in place to ensure that people know what services and treatment is available, especially those aimed at people who are disadvantaged from using services.
- Increase the number of people with diabetes who are achieving NICE targets for care management and the numbers of people who are receiving all of the nine NICE key processes of diabetes care reported in the National Diabetes Audit.

2.2.10 Domestic Abuse

Domestic abuse occurs across the whole of society, regardless of sex, race, ethnicity, religion, age, class, income or where they live. There may, however, be some increased risk in vulnerable groups such as women who are transient, those who have low socioeconomic status, and those who have mental health problems.

The majority of domestic abuse is committed by men against women. Women are most at risk of serious violent assault when separating or after separating from an abusive partner.

Other forms of abuse include adolescent to parent abuse, as well as issues like female genital mutilation and forced marriage.

Since April 2011, there has been a statutory duty for Community Safety Partnerships to conduct Domestic Homicide Reviews (DHRs). Since that time there have been ten DHRs commissioned in Kent involving 13 deaths.

A number of awareness raising campaigns have contributed to a large increase in the number of victims reporting domestic abuse in Kent. This is putting those services dealing with domestic abuse under significant pressure.

Since 2006 over 20,000 domestic abuse incidents have been reported to Kent Police every year. This number is rising and during 2013-14 there were 25,365 incidents reported. This is an increase of 8.4% from 2012-13.

In the 12 months to October 2014, 1,862 high risk cases were referred to Multi Agency Risk Assessment Conferences (MARACs), with 2,394 children living in those high risk households. This is an increase in 32% on the previous year.

During 2014-15 (the second year of the service) the Kent and Medway Independent Domestic Violence Advisors (IDVA) service received 2,581 referrals which is an increase of 39% from the previous year.

Between July 2014 and June 2015, 2,410 people were assisted at domestic abuse one stop shops across Kent, an increase of 31.3% compared to the previous year.

Currently each service is commissioned separately, but given that demand is increasing at a time where budgets are falling in many of the commissioning agencies, redesigning the way services are commissioned may offer an opportunity to improve services through greater integration.

Most investment currently supports those victims assessed to be at the highest risk. Whilst understandable, a new service should consider what support is needed to prevent abuse in the first place and stop medium and standard risk victims becoming high risk.

Recommendations:

- Commissioners should examine whether it is possible to combine the provision of domestic abuse services into a single commissioned service as well as whether it is possible to commission services which increase the number of victims who can be supported to safely stay in their own home.
- Training for frontline health care workers and other appropriate professionals should be made available and disseminated throughout Kent. This training should detail how to raise awareness and how to signpost to appropriate services.

2.2.11 Gypsy, Roma and Traveller Populations

The Gypsy and Traveller communities have a long tradition of residing in Kent and members of these communities have settled and integrated with the general Kent population, although many retain a cultural identity that has distinct differences to the rest of the population.

The definition of individual Gypsy, Roma and Traveller communities and community members is complex as they are not one homogeneous group. The perceived identities of Gypsies, Roma and Travellers are affected by myths, stereotypes and historical interaction between communities.

Gypsy, Roma and Traveller communities have poor levels of health, even compared with other marginalised groups; high rates of infant mortality, and difficulties in accessing healthcare. Poor school attendance, low educational attainment and high levels of illiteracy are also particularly acute problems for Gypsy and Traveller children.

Census data show that Maidstone and Swale are the two local authorities in England ranked with the highest proportion of the Gypsy and Traveller population, with Ashford having the fifth highest.

2.2.11.1 Unmet Health Needs

There are areas of unmet health needs for Gypsy, Roma and Traveller communities in Kent. Those in touch with the health trainer service clearly benefit from this, both in raising awareness and building confidence to access appropriate services in a timely manner.

Knowledge and awareness of how to access health services like GPs, family planning, national screening programmes and dentists appear to be particularly low amongst the Roma community in Kent.

Educating health care professionals, community members, and community leaders to raise awareness is vital if the health needs of this community are to be met. The production of DVDs explaining how and when to access different health services in Slovak or other languages could help. This could lead to increased knowledge and awareness of health services in the Gypsy and Traveller communities and would also have a positive impact because there are higher levels of illiteracy in comparison to the rest of the population.

Access to dental services is an issue for these populations. Innovative solutions such as a mobile dental unit with both a male and female dentist on board should be considered to improve access to treatment. Work could be done in partnership with voluntary sector organisations and with the various communities themselves, to identify specific dental practices with a particular interest in developing and promoting their services to this population.

There are issues around the provision of identification required by GPs in order to see Gypsy, Roma and Travellers which requires better guidance to GPs. Guidance could also highlight the particular difficulties that Gypsy, Roma and Traveller communities face in accessing primary care.

Recommendations for commissioning:

- Additional health trainers or community workers who have an understanding of the language and cultural issues should be considered for areas where there is a

relatively high proportion of Gypsy, Roma and Traveller populations. It would ensure representation for wider community groups, including Roma community members and male representatives from the community.

- Immunisation education through health visitors or community nurses, alongside health trainers/community workers would encourage more parents to immunise their children and reduce the risk of outbreaks of certain communicable diseases.
- Work with and involve this community more around changing health beliefs and how they access health services. There may be scope to do this by utilising health trainers to perform targeted work.
- Commission services that aim to change lifestyle behaviour such as the Stop Smoking Service and drugs and alcohol services ensuring that there is appropriate outreach service offered to Gypsy, Roma and Traveller communities.
- Improve the coverage of Gypsies, Roma and Travellers in ethnic monitoring relating to health and social care to address their 'invisibility' in public health terms.
- Commission training that improves the knowledge of staff around the cultural needs of Gypsy, Roma and Traveller communities, particularly those who are delivering primary health care services. Training could be formal, but could also be offered online or via the production of a DVD to ensure wider coverage.
- Commission the provision of appropriate audio visual material for this community to facilitate better understanding of and access to healthcare services.
- Commission flexible dental services best suited to the needs of this population.
- Ensure there is provision of guidance to all GP practices across the county, making clear that that they do not need to insist on three forms of identification in order to see Gypsy, Roma and Travellers.
- GP practices should apply discretion and flexibility when approached by Gypsy, Roma and Traveller community members for access to primary care.

2.2.12 Health Checks

NHS Health Checks systematically target the top seven causes of preventable disease and mortality: high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption. It is primarily a health improvement programme offering a genuine opportunity to engage people aged 40-74 in discussions about healthy lifestyles before they get sick and goes on to help them to take control of their health and take action to avoid, reduce or manage their risk of developing future health problems.

a The NHS Health Check (HC) programme is a national cardiovascular disease (CVD) risk assessment programme that began in 2009 and became a mandated responsibility for the NHS in 2012. This responsibility transferred from the NHS to local authorities with Public Health in March 2013.

b It is a five year rolling programme that assesses an individual's risk of CVD. CVD includes heart disease, stroke, diabetes, kidney disease and vascular dementia.

Patients already diagnosed with any of these conditions, have hypertension, are already on a statin medication to control cholesterol or are receiving palliative care are not eligible and are therefore excluded from the invitation process.

c Kent has an annual target to invite 20% of the current eligible population which is estimated at 455,591 for 2015-16. The programme aims to check 55% of the invited population equating to 48,893 in 2015-16.

d Performance of NHS Health Checks in Kent improved significantly in 2014-15 with a rise in uptake of the eligible population from 32,924 checks being completed in 2013-14 (34.7% uptake) to 45,623 checks in 2014-15 (50.6% uptake).

2.2.12.1 Benefits of Health Checks

The Office for National Statistics (ONS) 2010-based principal population projections for England, project that between 2010 and 2022 the number of people aged 65 or over will rise by 27% and the number aged 85 or over will rise by 44%. Eighty per cent of those aged 65 and over will need care in the later years of their life. These demographic trends are exacerbated by an increasing prevalence of CVD in the population.

Together, the vascular conditions identified by the NHS Health Check are the biggest cause of preventable deaths in the UK, affecting more than four million people. The NHS HC programme offers people an opportunity to stall some of these trends and thereby reduce current cost predictions by preventing the onset of vascular disease and vascular dementia through support and management of behavioural and physiological risk factors.

2.2.12.2 Priorities for Kent

One of the programme's objectives is to contribute to narrowing health inequalities. Kent is working to tailor the delivery of the programme in a number of ways to achieve this. Although local authorities have a duty to offer the NHS Health Check to all eligible people, in Kent the imperative is to work towards prioritising invitations to individuals with the greatest health risk. For example, by prioritising invitations to people with an estimated ten-year CVD risk score greater than 10% or those living in the most deprived areas. Public Health England is supportive of this approach.

2.2.13 Health Inequalities

Differences in socioeconomic status lead to the health inequalities across society: the unfair and avoidable differences in health status between individuals depending on life circumstances and opportunities. This was the central message in the 2010 Strategic Review of Health Inequalities in England, also known as The Marmot Review: that efforts to reduce health inequalities must address these broader underlying social determinants.

Tackling health inequalities in Kent has become a key aim for Public Health, and in 2012 the "Mind the Gap" action plan was formulated. The strategy was an opportunity to produce a

unified plan to guide the actions of KCC departments, district councils, and community partners, in efforts to reduce health inequalities across the county.

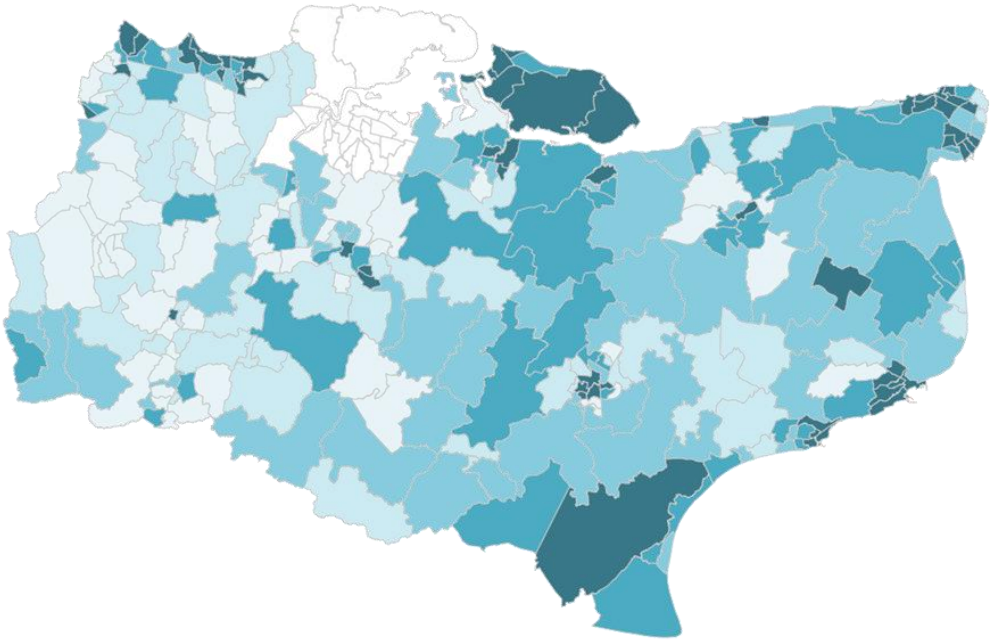
In 2015, Public Health England published analysis of Kent's performance on health inequalities against the Marmot objectives. The results are found in table 3 below: green denotes values better than the England value, yellow denotes no significant difference and red denotes worse than the England value.

Table 3: Marmot Indicators for Local Authorities in England, 2015: Kent, Public Health England

Health outcome indicators	Kent	South East	England	Data period
Healthy life - expectancy at birth - Male (years)	62.8	65.6	63.3	2011-2013
Healthy life - expectancy at birth - Female (years)	66.4	66.7	63.9	2011-2013
Life expectancy at birth - Male (years)	79.9	80.4	79.4	2011-2013
Life expectancy at birth - Female (years)	83.6	83.9	83.1	2011-2013
Inequality in life expectancy at birth - Male (years)	7.1	-	-	2011-2013
Inequality in life expectancy at birth - Female (years)	5.1	-	-	2011-2013
People reporting low life satisfaction (%)	4.2	3.8	4.8	2014/15
Giving every child the best start in life				
Good level of development at age 5 (%)	68.5	64.2	60.4	2013/14
Good level of development at age 5 with FSM status (%)	51.8	46	44.8	2013/14
Enabling all children, young people and adults to maximise their capabilities and have control over their lives (FMS – free school meals)				
GCSE achieved 5A*-C (%)	58	59	56.8	2013/14
GCSE achieved 5A*-C with FSM status (%)	27.3	28.6	33.7	2013/14
19-24 year olds not in education, employment or training (%)	-	16.1	15.9	2014
Create fair employment and good work for all				
Unemployment %	5.4	4.8	6.2	2014
Long term claimants of Jobseeker's Allowance (per 1,000)	5.6	3.6	7.1	2014
Work-related illness (per 100,000)	-	4060	4000	2013/14
Ensure a healthy standard of living for all				
Households not reaching Minimum Income Standard (%)	-	21.1	24.4	2012/13
Fuel poverty for high fuel cost households (%)	8.6	8.1	10.4	2012/13
Create and develop healthy and sustainable places and communities				
Utilisation of outdoor space for exercise/health reasons (%)	12.1	18	17.1	2013/14

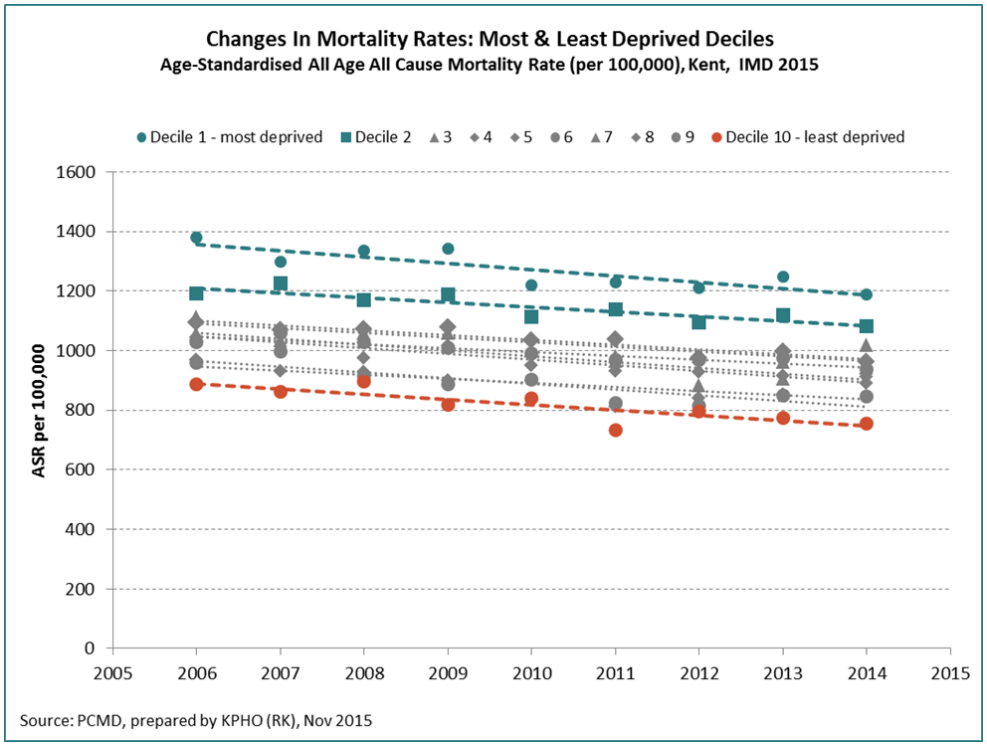
Whilst Kent scores above the England average on a range of indicators, this countywide analysis hides the great diversity and disparities which exist within and between Kent's communities. In 2015, updated measures for the Indices for Multiple Deprivation (IMD) were released nationally. This combines data drawn from seven domains: income, employment, education, skills, health, crime, housing and the environment, producing an overall deprivation score for geographic areas. The map of Kent below (Figure 6) shows that high deprivation (dark blue) is found in the east of Kent particularly around coastal towns and urban centres. The west of Kent is relatively affluent by comparison (light blue). Local Kent data demonstrates that poorer health behaviours and outcomes correlate strongly with these deprived areas: obesity prevalence, smoking prevalence, teenage pregnancy rates, alcohol related disease, registered disease prevalence, to name a few.

Figure 6: Indices of Multiple Deprivation 2015 (IMD) Ward map by quintiles, for Kent



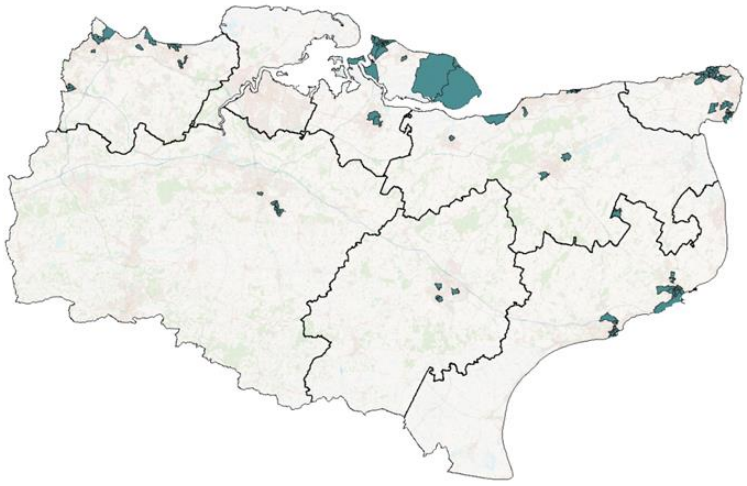
Whilst health outcomes have been improving for Kent as a whole, the differences in these outcomes between affluent and deprived populations persist. The graph below, Figure 7, highlights this: whilst mortality rates are coming down across all deprivation deciles, the gap between the most affluent (the bottom line) and the most deprived (the top line) has not changed over the last 10 years, suggesting that efforts to tackle health inequalities are not yet having an impact on mortality rates.

Figure 7: Changes in Mortality Rates by Deprivation Decile in Kent 2006-2014



What is noticeable in the latest mortality and life expectancy data is that the tenth decile (most deprived), suffer disproportionately poorer health outcomes than other deciles. Analysis indicates that excess premature mortality in these areas is primarily caused by preventable chronic diseases which are the result of behavioural risk factors such as smoking, physical inactivity and poor diets. A new strategy is being developed that aims to focus efforts towards the most deprived geographic areas in Kent (Figure 8). This will have the greatest impact on reducing health inequalities and the life expectancy gap.

Figure 8: Most Deprived Decile LSOAs in Kent by IMD 2015



Recommendations:

- Focus efforts to reduce health inequalities on the geographic areas of the greatest deprivation, providing detailed analysis and mapping of these areas.
- Develop a multiagency response to recognise and act upon the social determinants of health, such as education, housing and green spaces.
- Engage with primary care and service providers in deprived areas to promote healthy behaviours and improve the detection and management of chronic disease.
- Engage local communities to foster wellbeing and resilience using an asset-based approach.

2.2.14 Healthy Weight

The causes of obesity (commonly defined as a BMI of 30 or more) are complex and although some are genetic, most are modifiable.

The prevalence of obesity varies across Kent, with the highest prevalence rates of adult obesity to be found in Dartford, Shepway and Swale. The highest rates in four to five year olds are found in Shepway, Dartford, and Swale. The highest rates in 10 to 11 year olds are found in Gravesham, Thanet and Dover. The Kent trend has not significantly changed in year R and year 6 for overweight, obesity and excess weight 2010-11 to 2014-15.

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

Obesity in pregnancy has serious risks for mother and child and the Chief Medical Officer has raised risks to women in her Annual Report 2015. An increasing number of obese children are at risk of a number of serious conditions including Type 2 diabetes, cardiovascular disease, certain cancers, lung disease and kidney failure which will follow into adulthood. Adults who are obese have a much higher risk of a number of serious conditions including diabetes, heart disease, stroke and arthritis than the general population and experts are recognising an increasing number of people with severe and complex obesity.

There are specific groups who have more of a predisposition to specific long term conditions with a lower BMI than the general population (NICE PH 46). These include:

- South Asian people are immigrants and descendants from Bangladesh, Bhutan, India, Indian Caribbean (immigrants of South Asian family origin), Maldives, Nepal, Pakistan and Sri Lanka.
- African Caribbean/black Caribbean people are immigrants and descendants from the Caribbean islands (people of black Caribbean family origin may also be described as African American).
- Black African people are immigrants and descendants from African nations. In some cases, they may also be described as sub Saharan African or African American.

- "Other minority ethnic groups" includes people of Chinese, Middle Eastern and mixed family origin.
- It is important that commissioners of services need to acknowledge such population differences.

2.2.14.1 Economic Burden

Table 4: Estimated Additional Costs Related to Obesity to CCGs by 2030

CCG	2012 registered population*	% Kent population	Additional cost (£m)
NHS West Kent CCG	466,245	31.1%	£17.2m
NHS Dartford Gravesham and Swanley CCG	248,912	16.6%	£9.1m
NHS Ashford CCG	123,536	8.2%	£4.5m
NHS Canterbury and Coastal CCG	212,388	14.2%	£7.9m
NHS Swale CCG	108,377	7.2%	£4.0m
NHS Thanet CCG	139,545	9.3%	£5.3m
NHS South Kent Coast CCG	200,403	13.4%	£13.4m
Total	1,499,422	100%	£55.4m

*NHS England - CCG 2012 registered population

This will also have an increased impact on social care costs. In addition obese people are less likely to be in employment than people of a healthy weight and the associated national welfare costs are estimated to be between £1 billion and £6 billion.

Weight management programmes should have physical activity, nutrition and behavioural change components to meet National Institute for Health Care and Excellence (NICE) guidance. Interventions should ideally result in at least a five per cent reduction in body weight. Evidence now supports an understanding that a lower level of weight loss maintained over a life time may be a more realistic goal and that weight management interventions should achieve at least an average three per cent reduction in weight that is maintained. NICE calls for the need for further research on methodologies for sustaining weight loss achieved over a lifetime. However, commissioned interventions to identify people who are both at risk and motivated and then followed into a maintenance phase could be part of a model for Kent, and may contribute to the obesity research base.

A clear strategic direction is needed to integrate all the action that is necessary and to facilitate co-commissioning where this adds value. The challenge is to work at scale to mobilise existing resources and assets to tackle obesity through the organised efforts of society.

Recommendations:

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

2.2.15 Mental Health

Mental illness, like physical illnesses, is on a continuum of severity: ranging from mild to moderate to severe. Around 20% of adults in Kent will suffer from some form of mental health problem, which is around 220,000 people in any given year. However the number of people who seek help for their conditions is far lower. This is often due to stigma that is associated unfairly to mental illness, which can prevent people from seeking help. The severe consequences of this can often be either their condition gets much worse or tragically, ends with suicide.

2.2.15.1 The extent of mental illness in Kent

There are over 200 different mental health conditions and the Mental Health Needs Assessment for Kent provides more information on this large topic.

There are, however, two broad ways to categorise mental health problems:

1 common mental health problems (mainly anxiety and depression)
2 serious and enduring mental illness (mainly psychosis and bipolar mood disorders).

The way the number of people with mental health problems is calculated is by using the results of national survey data, The Adult Psychiatric Morbidity Survey and applying it to the Kent population.

By this method in Kent:

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

The majority of people with the worst mental health in Kent are aged 35-65 years old. The over 65s also face non dementia related depression and anxiety, however, with the estimated number of people with depression over 65 in Kent being approximately 20,000.

2.2.15.2 Link with socioeconomic and social conditions

There is a strong link between the severity and duration of common mental illness and socioeconomic conditions. Dartford and Thanet are the districts in Kent with the highest predicted rates of people with common mental illness.

2.2.15.3 Psychosis and bipolar affective disorder

In Kent there are an estimated 5,000 people who have chronic long term severe mental illness and the new cases/ incidence rates are calculated to be 18 per 100,000 (aged 16-65). This is lower than the national average. If people access services in a timely way, there is good evidence that treatment is effective. There are 11,000 adults recorded on GP data bases with severe mental illness in Kent.

2.2.15.4 Success treatment rates: ranges

Schizophrenia 45–60%; major depression 65–80%; bipolar disorder 80%; panic disorder 70-90%.

Another way to understand the level of poor mental health for people with severe mental illness is to assess the admission rates to hospital by people for mental illness. Canterbury and Thanet have the highest hospital admission rates for mental illness in Kent.

2.2.15.5 At risk/vulnerable groups

- perinatal mental health: estimated 2,000 women with postnatal depression
- 70% of prisoners have a mental health problem
- 19% of people in substance misuse services also getting mental health treatment.

2.2.15.6 Physical health of people with mental health problems

People with mental illness die on average 20 years younger. They die of chronic health conditions such as CVD, stroke and COPD.

a Nearly a third of all people with long-term physical conditions also have a mental health problem such as depression or anxiety.
b Mental illness has the same effect on life expectancy as smoking, and more of an effect than obesity.
c Mental illness accounts for nearly as much morbidity as all physical illnesses put together.
d 16.7% of people in England who completed a 2007 household survey that they had thought about committing suicide at some point in their life.

There is a continuing requirement to better understand the needs of people with “personality disorder” who are accessing Kent’s mental health services.

Recommendations:

a Commission local community asset mapping and development, and engagement, thereby enabling people to feel connected and in control.
b Continue commissioning psychological therapy.
c Ensure all front line professionals feel equipped to tackle emotional wellbeing and sign post to early help for community wellbeing.
d Improve social and community support via integrated work from troubled families, drug and alcohol services, mental health services and criminal justice systems.
e Focus on perinatal mental health and wellbeing: use opportunities of public health commissioning for health visiting to secure robust commissioning of midwives, maternity units and the Mental Health Pathway for perinatal mental health.
f Train psychiatric staff to be more vigilant and better equipped to notice a patient's physical health deterioration.
g Train mental health staff in healthy lifestyle awareness.
h Workforce wellbeing initiatives to be targeted in mental health trusts.
i Follow NICE guidance: where physical health of mental health patients is the responsibility of the GPs and primary care.

Dual diagnosis recommendations:

a Joint commissioning for mental health and substance misuse needs to become the norm. CCGs and local public health structures need to work together with aligned pathways and contracts. It is particularly important that NHS and Public Health England also commission, together with local public health in the county council.
b Concerns exist that the mental health cluster for "dual diagnosis" is too restrictive and that people with 'dual diagnosis' may be excluded from the Substance Misuse PbR pilot. The two payment systems must work together.
c Health and wellbeing boards need to offer a joint forum with Crime and Safety Partnerships to understand the needs of offenders.
d Joint outcome measures are needed between mental health services and substance misuse services.

2.2.16 Offenders and Detained Persons

As of October 2015 there were five prisons in Kent actively being used to house offenders:

- Elmley (1,151 prisoners)
- Swaleside (1,109 prisoners)
- Maidstone (591 prisoners)
- Stanford Hill (460 prisoners)
- East Sutton women's prison (90 prisoners).

Source: https://www.gov.uk/government/statistics/prison-population-figures-2015

In addition there is also the Dover Immigration Removal Centre.

Drug use (including the use of new psychoactive substances) is a growing concern in prisons, and the 2015-20 Kent and Medway Suicide Prevention Strategy identified prisoners as one of the population groups at highest risk of suicide.

The mental health of prisoners is also concerning according to the Prison Reform Trust:

- 26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody
- 49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression
- women in prison are more than three times as likely to be identified as suffering from depression as women in the general population (65% v 19%)
- in 2014, women accounted for 26% of all self-harm incidents in prison in England and Wales despite representing only 5% of the prison population.

Source: www.prisonreformtrust.org.uk

Prison health services are commissioned by NHS England. A full range of services should be available in prison (GPs, mental health, substance misuse etc.).

During 2014, probation services were restructured nationally and there are now two providers of probation services in Kent. The Community Rehabilitation Company (CRC) is managed by Seetec and delivers rehabilitation services to people who have been given a custodial or community sentence by a court. The National Probation Service supervises high risk offenders released from prison into the community.

According to Government statistics the CRC was supervising 7,512 individuals (6,509 men and 1,003 women) across Kent, Surrey and Sussex in June 2015.

Source: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/471449/csv-datasets-variable-guides.zip

According to the Kent Probation Community Offenders Health Needs Assessment 2013, Kent and Medway community offenders have the following health needs:

- At least double the mental health needs of the general population
- 66% with substance misuse needs
- 43% or more with alcohol misuse needs
- 20 - 30% with a learning disability need
- 52 - 80% with smoking cessation needs.

They are a younger cohort than the general Kent and Medway population and therefore less likely to have a long-term condition but they do however engage in risky lifestyle behaviour that can result in a long-term condition.

Source: http://www.kpho.org.uk/__data/assets/pdf_file/0020/43085/KM-Community-Offenders-Final-Documen-3rdMarch-2014-V16-2-1.pdf

Recommendations:

a A refreshed health needs assessment of the prison population in Kent should be undertaken, and the community offender health needs assessment and Kent Police Custody Suites should be updated.

b Support the Kent Integrated Data project by comprehensive data sharing between health services in prison, health services in the community, the police and probation services should be considered to help design and evaluate effective health services.

2.2.17 Physical Activity

Physical inactivity is directly responsible for a range of non-communicable disease conditions and has been identified as the cause of 17% of annual all-cause mortality, and reduces life expectancy by three-five years. The cumulative annual cost of physical inactivity to local authorities in Kent has been calculated at just over £264million.

Physical inactivity is defined as an adult who achieves less than 30mins of moderate physical activity per week. In Kent, 28.37% of adults are currently classed as physically inactive and are at the highest risk of developing or are already suffering disease conditions as a result of a lack of physical activity.

The Chief Medical Officer also recommends that adults achieve 150mins of moderate physical activity or 75mins of vigorous physical activity per week in order to maintain or improve health. Kent performs poorly in comparison to the national average on both measures. Only 56.57% of adults in Kent currently meet this recommendation.

There is a strong relationship between levels of physical inactivity and socio-economic status, so much so that people living in the most deprived areas are twice as likely to be physically inactive as those living in the least deprived areas. Other physical activity concerns in key demographic groups conclude that men are more active than women in virtually every age group, and that physical activity declines with age to the extent that by the age of 75 years, only one in ten men and one in 20 women are active enough for good health.

Physically inactive people from populations in areas of highest deprivation should be considered the primary target group for increasing levels of physical activity.

Recommendations:

a That programmes be commissioned to address physical inactivity based on the brief intervention and motivational interviewing model.
b Opportunities should be explored to embed physical activity care pathways in primary care services and in lifestyle-focussed health improvement services.
c Increase levels of physical activity including integrating physical activity into transport and environmental planning and services, improving physical activity assets and facilities in response to local demand.
d Use of the natural environment for physical activity and health reasons should also be increased.

2.2.18 Planned Care

The principle is to deliver integrated outpatient and day case elective care services for Kent patients, ensuring that treatment is delivered in the right place by the right clinician, first time and without the requirement for unnecessary appointments or hospital visits, while reducing costs and driving improvements in quality and outcomes.

There were 208,559 elective inpatient admissions costing approximately £191 million and 1,891,981 outpatient visits in Kent in 2014-15. Total elective care activity has increased in 2014-15 across Kent with the exception of Dartford, Gravesham and Swanley. Elective day case admissions have decreased since 2013-14 across Kent with the exception of West Kent. Outpatient first attendance rates have increased, especially in Dartford, Gravesham and Swanley, and Swale CCGs. The highest first appointment/ follow up ratios were seen in the specialities for oncology, nephrology and haematology across all CCGs. Swale and Thanet CCGs had particularly high ratios for old age psychiatry (1:26 & 1:19 respectively). No specific explanation is available for this. GP survey results appear to show Canterbury and Coastal CCG having slightly better patient experience compared to other CCGs.

An assessment of need and demand for trauma and orthopaedic (T&O) care in East Kent was carried out in 2015. There has been an increase in elective T&O activity in NHS South Kent Coast, NHS Thanet and NHS Ashford, while activity in NHS Canterbury and Coastal has shown some fluctuation. The most important drivers of this phenomenon are increasing life expectancy, which is associated with an increase in the prevalence of chronic disease, and the rising prevalence of obesity. Approximately 17% of knee osteoarthritis is due to obesity. Demand for orthopaedic services has put pressure on providers of orthopaedic care, which is reflected in increasing numbers of people on the waiting list for orthopaedic appointments. This has led to a decrease in the proportion of patients meeting the 18 week referral to treatment time target.

Prevention remains central to managing orthopaedic need. Strategies which focus on reducing excess weight, promoting physical activity and reducing falls will decrease the need for both emergency and elective orthopaedic care. Strategies to improve service delivery should be implemented and evaluated, such as better triaging, consultant oversight, increasing existing capacity, and ring fencing elective beds/theatre time.

2.2.19 Screening

The National Screening Committee reviews the evidence and advises the Department of Health that there should be the following national screening programmes in England:

- antenatal and newborn screening (several sub programmes)
- three cancer screening programmes: cervical, breast and bowel
- diabetic eye screening: to prevent blindness
- abdominal aortic aneurysm screening: to prevent rupture of the aorta and death.

New programmes and changes to existing programmes are planned and this can be viewed on government websites. In West Kent, the bowel scope screening programme for 55 year olds is well underway. In East Kent, the programme will start in 2016.

Antenatal screening is performed as part of routine healthcare. Pregnant women are tested for syphilis, hepatitis B and HIV, for the blood disorders thalassemia and sickle disease and for chromosomal and developmental abnormalities e.g. those for Down's syndrome. Babies are tested at birth for several diseases where early treatment can help, e.g. cystic fibrosis. They are also examined for hearing, hip, eye, heart and testicular problems.

The other programmes all require people to be invited for screening. Overall, Kent compares reasonably well in that the response to invitations is good. Higher uptake, however, would offer more benefit overall. Services seek to make sure everyone has informed choice and that screening, if desired, is easily accessible.

Screening can help to reduce health inequalities, but only if uptake is high. This is especially true for poorer areas or for groups that tend not to seek health service help so readily. A map of uptake levels, showing the percentage of people taking up bowel cancer screening, clearly shows that uptake is lower in poorer areas despite efforts to promote the programme.

In Kent, as elsewhere, these programmes are closely co-ordinated and monitored to ensure high standards are kept. Programmes of work to increase uptake are undertaken though the local Public Health Screening Team which is embedded in the organisation that commissions the services, NHS England South (South East). It also works with colleagues in clinical commissioning groups in Kent and Kent County Council to improve the screening system.

Statistics relating to coverage, uptake, performance and quality are available on government and NHS websites.

2.2.20 Sensory Impairment

Sensory needs cover groups of people who suffer from three types of impairments: people who are sight impaired, people who are deaf, deafened or hard of hearing, and finally people who have a combined sight and hearing impairment or who are deafblind.

The latest (May 2015) Public Health Outcomes Framework data indicate Kent as having relatively lower rates of sight impairment (AMD, glaucoma and diabetic retinopathy) when compared to the England average.

The impact of eye disease, sight impairment and blindness increase exponentially with age (for both individuals and populations); half of this is preventable if caught early. Health outcomes of eye disease are significantly better if detected and treated early. The main causes of sight impairment in the UK have a higher incidence among the over 65s. Those with learning disability are also a population with higher levels of prevalence and may also have some degree of deafness.

The main key issues and gaps identified in the JSNA 2013 have not materially changed except for some continuing work by the Kent and Medway Eye Health Local Professional Network. They have prioritised the provision of an eye screening service for children in parts of Kent (apart from East Kent) where there is a lack of service provision. Data from the Joint Sensory Needs Assessment (2013) highlights this and other gaps. The Network is also assessing the future direction of assessment projects and the priority of these projects.

Further work is intended to be carried out on locality prevalence rates, service mapping, current levels of activity, pathways and the identification of additional unmet needs and gaps in both health and social care services.

Recommendations:

a Providers should be encouraged to provide a co-ordinated and integrated seven day a week eye care service in line with the NHS plan for seven day a week services.

b For there to be put in place a uniform children's vision screening system across the whole county, orthoptist led, in accordance with the most recent guidelines.

c Eye Clinic support (Eye Clinic Liaison Officers or an equivalent role) should be part of the CCG ophthalmology service specifications.

d Accessible, equitable and efficient provision of services for people with low vision should be established across all of Kent and Medway meeting the standards and specifications of the Local Optical Committee Support Unit (LOCSU) Pathway for the provision of low vision services.

2.2.21 Sexually Transmitted Infections (STIs)

In 2014, the rate of new STI diagnosis was 576 per 100,000 population in Kent; lower than the England average, which is 797 per 100,000 population.

The greatest burden of diagnosed sexually transmitted infections (STIs) is found amongst those aged 25 and under. Detection has increased following the introduction of the national chlamydia screening programme for 15-24 year olds. The highest chlamydia detection rate amongst 15-24 year olds is seen amongst females. In 2014, this was 2,435 per 100,000 female aged 15-24 population in Kent and 2,664 per 100,000 females aged 15-24 population in England. In Kent, the chlamydia detection rate is 1,738 per 100,000 15-24 year old population lower than the England average of 2,012 per 100,000 15-24 year old population. The infections diagnosed most frequently continue to be genital warts and chlamydia.

Many STIs have no symptoms and therefore the true burden of infections is unknown as both knowledge of and use of condoms is low. Whilst there is some awareness that condoms can protect against STIs, there is limited knowledge about the risk of transmission and that many STIs show no symptoms.

The prevalence of late diagnosis of HIV in Kent remains higher than the England average. A public awareness campaign and health professional development to encourage HIV testing

were undertaken in response to the research findings undertaken within a Health in Europe programme to look at the late diagnosis of HIV in Kent, Medway and Picardy. The volume of HIV tests undertaken has increased. A slowing down in the volume of late diagnosis of HIV has been observed, even though the prevalence of late diagnosis remains higher in Kent than the England average.

The preferred method of contraception used continues to be oral contraception. Injectable is the most frequently used long acting contraception.

The rate of GP prescribed long acting reversible contraception (LARC) (excluding the injectable long acting method) in 2014 was higher in Kent than England. The crude rate of GP prescribed LARC per 1,000 resident female population aged 15-44 years in Kent was 38.0 and in England 32.3.

Recommendations:

- Increased activity to detect chlamydia amongst males aged 15-24 years.
- Further in depth behaviour analysis.
- Variation in the detection of STIs across the districts requires further investigation

2.2.22 Smoking and Tobacco Control

In 2014, smoking prevalence increased slightly to an estimated 19.1% of the Kent population from the previous year which is a reversed trend from the national reduction of 18.4% in 2013 to 18% in 2014. Smoking prevalence among routine and manual occupation groups, however, has reduced in Kent to 25.8%, 2.2% below the national average (28%). This may reflect the additional focus on local Stop Smoking Services and national campaigns which have adopted targeting services where there is greatest need.

Smoking in pregnancy continues to be a challenge in Kent, despite the smoking status at time of delivery (SSATOD) decreasing from 13% (2013-14) to 12.6% (2014-15). The national SSATOD rate has also decreased from 12% to 11.4% respectively. It is suggested that increased compliance and quality assurance of the Kent BabyClear programme can help yield further results.

In the last year, routine data on smoking status at the age of 15 has become available, recording data from the What About YOUth (WAY) survey providing estimates on:

- smoking at age of 15: current smoker
- smoking at age of 15: regular smoker
- smoking at age of 15: occasional smoker

Although estimates, these new indicators enable authorities to plan appropriate and effective preventative campaigns and cessation programmes to meet the needs of young people who smoke. This is particularly important, as it is reported that two thirds of smokers started smoking before the age of 18 and 80% started before the age of 20. (ASH 2015)

Kent Fire and Rescue have trained their staff in VBA and promote smoking cessation at their Lung Age Roadshow.

Recommendations:

a Promote campaigns that encourage smokers to give up smoking.
b Work collaboratively with CCGs to reduce smoking and the harms caused by smoking, including those with long term conditions and pregnant women who smoke.
c Reduce inequalities of smoking prevalence across different social and ethnic groups.
d Ensure that smoking quit services are linked to other primary and acute settings, such as hospitals, pharmacies, GPs etc.
e Ensure policies and support services are updated in line with changes in e-cigarette legislation and developments.
f Target and reduce the number of children and young people who smoke.

2.2.23 Substance Misuse: Alcohol and Drugs

Alcohol dependence is the most common form of substance misuse, but any drug, including heroin, cocaine, crack and cannabis, comes into this category, as does the misuse of glue and aerosols.

2.2.23.1 Alcohol

The current guidance is that if people drink around 14 units per week, this is likely to be safe and will minimise alcohol related harm to their bodies. Pregnant women are advised to drink no alcohol at all. Drinking regularly above these levels can be hazardous (risky) and ultimately harmful (cause damage to the body that can result in liver and other cancers, as well as many other problems).

Most people in Kent drink responsibly, around 70%. Approximately 245,000 people in Kent (21%) are, however, estimated to be drinking at increased risk levels and around 82,000 people are estimated to be high risk drinkers (i.e. they are dependent on alcohol and have harmed their bodies) and this is about 6% of the Kent population. There is also the behaviour of binge drinking: consuming a large (eight + units) amount of alcohol in one go. The estimated number of people in Kent binge drinking is around 200,000 people.

Younger age drinkers (under 18 years) continue to decline in Kent and UK. The majority of people who are misusing alcohol are in the 35-65 age range and although men are still the greatest misusers, women are rapidly catching up. For women, alcohol misuse unfortunately places greater risks because not only are their bodies lighter and smaller than men, but they risk harming their unborn child if they drink in pregnancy.

The main intervention for tackling alcohol misuse is called IBA or Identification and Brief Advice. This is a short and simple intervention: assessing how many units a person drinks and then asking that person to cut down and, if needed, monitoring this for a few weeks. Evidence has shown that this simple intervention can dramatically help people. Those

people, once identified, can be referred to Kent Public Health commissioned treatment providers.

Those people who are likely to benefit from structured treatment are called “dependent drinkers”.

There are likely to be around 68,000 people with some degree of alcohol dependence in Kent.

In Kent there are estimated to be:

- 63,000 people with some mild dependence
- 4,500 people with moderate dependence
- 700 people with severe dependence.

Although Kent people are in general doing better than the England average in alcohol related deaths and hospital admissions, there are big differences across the county. In Kent, people from Thanet, Canterbury and Coastal and South Kent Coast CCG areas are most likely to suffer an alcohol related admission to hospital. Unfortunately the trend is on the increase. Liver disease and liver cancer are the biggest killers that are directly linked to alcohol.

2.2.23.2 Drug use

Based on data for 2011-12, the latest Kent estimates show that there are just over 13,000 people misusing opiates, crack and injecting substances in Kent. The most common illegal drug used is cannabis.

Levels of Class A drug use are generally stable around 9.0%. This follows a period of gradually decreasing proportions from a peak (12.0%) in 2003-04.

There has been a long-term decline in the use of any illicit drugs in the last year among younger adults (those aged 16 to 39), from 17.4 per cent in the 1996 survey to 13.0 per cent in the 2014-15 survey. This decline has not been seen in older adults (those aged 40 to 59), whose overall drug use in the last year has increased over the past 20 years from 2.5 per cent in the 1996 survey to the current level which is 3.6%. However over the past ten years it has remained broadly stable (3.8% in the 2004-05 survey, 3.6% in the 2014-15 survey). The trend for hospital admission for drug rehabilitation in Kent is falling. However drug related mental health admissions is increasing.

There has been an increase in drug related deaths and drug related poisoning remains one the highest causes of death in 20-30 year olds. The majority of these drug deaths were caused by morphine/ heroin overdose. The highest mortality was for people in the 40-49 year age group.

A relatively new issue is the rise of novel psychoactive substances (NPS) or “legal highs”. The prevalence of use is generally low, compared with the prevalence of well established drugs

such as cannabis, powder cocaine and ecstasy. Survey evidence shows that NPS use is predominantly confined to existing drug users.

2.2.23.3 Substance misuse services

In Kent substance misuse services are for both drug and alcohol. The services have excellent waiting time records, with 100% of people referred getting treatment within three weeks. There are no waiting lists as of January 2016.

In 2014-15 the numbers in treatment for drug misuse was 3,279, a 9% increase on the previous year. There is some evidence that there is greater relapse as there are more people dropping out of treatment than in previous years.

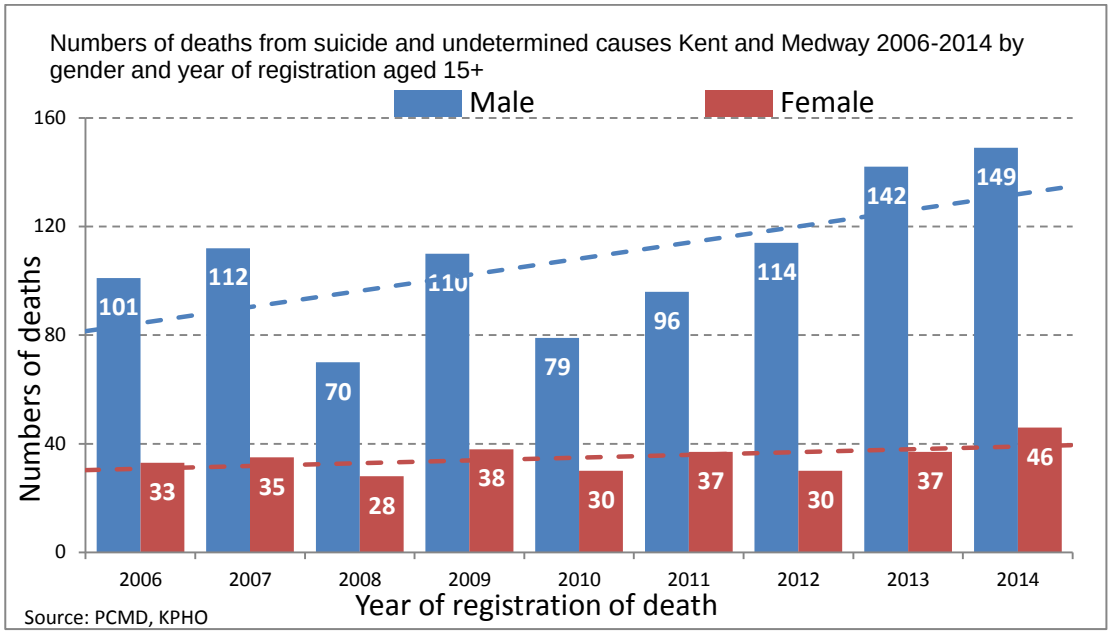
Recommendations:

- Identification and Brief Advice needs to be prioritised by a wide range of professionals and front line providers including GPs, housing workers, social workers. There needs to be better identification and referral to Kent's treatment providers.
- A focus on women drinking in pregnancy is needed in primary care, maternity and health visiting.
- Dual diagnosis (mental health and substance misuse) needs stronger joint commissioning and treatment arrangements so that clients do not fall through the gaps in provision.
- The use of medical/ pharmacological treatments for alcohol addiction needs to be explored in more detail by primary care, more specifically the joint support and responsibility of patients who are identified as high risk drinkers by both public health and NHS.
- The dangers of addiction from prescribed medication in primary care, needs to be investigated and avoided by CCGs.
- Better and more referral to substance misuse treatment providers in Kent by social services, Troubled Families and CCGs is to be encouraged.
- Investigation and shared learning across prisons, criminal justice, community and primary care about the nature and extent of drug related deaths is urgently needed.
- The use of steroids by men and the links to domestic violence needs further exploration. The data is scant but there is evidence that this is becoming a problem.
- Continued joint working with prison substance misuse services to ensure effective joint working and transition to community. The breaking of the offending cycle is critical.
- Ensure that RisKit and other risk awareness programmes for young people are embedded in schools and Early Help KCC services.
- Training for Troubled Families and Early Help workers on substance misuse in young people and families should be enhanced.

2.2.24 Suicide

Over recent years, there has been an increase in the annual number of people taking their own life in Kent and Medway. As illustrated below in Figure 9, the majority of this increase has been amongst men.

Figure 9:



In 2015, a new multiagency Kent and Medway Suicide Prevention Strategy was published. The strategy was developed by Kent County Council in partnership with Medway Council, carers' representatives, KMPT, Kent Police, coroners, CCGs and voluntary sector groups such as the Samaritans and Rethink.

The strategy identifies that certain groups within Kent are at higher risk of suicide than others. They are:

- Those in contact with mental health services
- Those who have self-harmed
- Offenders
- Middle aged and older men
- High risk occupation groups such as construction, agriculture and road transport drivers.

The priorities contained within the strategy mirror the national areas for action within the 2010-15 national strategy. They are as follows:

- Reduce the risk of suicide in key high risk groups
- Tailor approaches to improve mental health and wellbeing in Kent and Medway
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour

- Support research, data collection and monitoring.

These priorities also form the structure for the action plan which is contained within the strategy.

The issue of self-harm is also considered within the 2015 Kent and Medway Suicide Prevention Strategy. The Kent rate of hospital admissions as a result of self-harm amongst young people aged 10-24 is higher than the national rate; 389.2 per 100,000 in Kent during 2010-13 compared to 352.3 nationally during 2010-13. **Source**: Public Health England

Recommendations:

- Maintain the multi-agency suicide prevention steering group to implement the action plan contained within the 2015-20 Kent and Medway Suicide Prevention Strategy.
- Develop a social marketing campaign to address increasing suicide rates among men.
- Establish procedures for identifying and responding to suicide clusters.
- Conduct annual examinations of local suicide and self-harm statistics to identify local trends and priority groups.

2.2.25 Sustainability

There is a clear interdependency between public health, social care and sustainability. Health and wellbeing boards are required to consider wider social, environmental and economic factors that impact on health and wellbeing. The Sustainability Needs Assessment focusses on seven areas:

- **Planning and sustainability**

  Planning and use of green space in communities is essential to health and wellbeing, facilitating positive lifestyle choices and reducing health inequalities. Planners need to consider the needs of the future population, such as the ageing population and their housing needs, the risks and impact of severe weather events, green spaces, recreation, transport, and access to services. The forthcoming Housing Act and amendments to section 106 will have significant implications for the provision of affordable housing, whether private ownership, social housing or private rented sector. Demand for housing is also changing, with more people requiring one and two bedroom properties. District planners will need to manage tensions between demand and regeneration. In response to this, KCC has developed a health and planning online resource and health impact assessments are promoted.

- **Housing and fuel poverty**

  Being unable to afford to adequately heat a home increases the risk of ill health, hospital admission or possible premature mortality, particularly for vulnerable older people or those with a disability or long-term condition. The quality of available housing and welfare reforms will have an impact, particularly on those on a low income already

classified as in fuel poverty. In addition, changes to Government policy on Energy Company Obligation (ECO) has reduced funding for heating interventions or upgrades, even for those on benefits. Whilst other interventions are available, such as loft and cavity wall insulation, most properties have already taken advantage of these low cost interventions.

- **Transport**

Transport contributes to both positive and negative outcomes for population health. It is a great enabler, allowing greater and more rapid access to social activities and care services, but the majority of motorised transport (e.g. car use) produces carbon emissions that cause air pollution, leads to accidents that cause casualties, and contributes to declining levels of physical activity and its associated health implications. Thirty per cent of Kent's greenhouse emissions are due to transport, specifically particulate matter and nitrogen oxide. KCC is currently working with partners to promote sustainable transport, such as green buses, cycling and walking. Sustainable journeys are a feature of the new Local Transport Plan 4, due for adoption in 2016. KCC is producing its first Active Travel Strategy to promote making short journeys using physical activity and non-carbon producing means of transport.

- **Climate resilience**

Changes in weather patterns have created global interest in climate change and resilience. In Kent, the areas of climate change most likely to have the greatest impact on population health are: flooding, mortality and morbidity related to extreme temperature (heat and cold), food and water borne diseases; vector borne diseases, and air quality. Kent residents have suffered significant damage in recent years due to flooding and costs to the county council are estimated to be £2.5 million per year, whilst the cost to the wider economy is approximately £44 million per year. In addition to the financial cost for those affected by flooding, the cost to health and wellbeing is more difficult to quantify, but a 2008 study found poor mental health to be two to five times higher among individuals who had been subjected to flooding. Kent County Council, the borough and district councils and the Environment Agency work closely to reduce the effects of flooding in susceptible areas. The Paris 2015 summit saw 196 countries sign an agreement to address climate change, but results will need to be seen in the longer term.

- **Air quality**

Air quality is influenced by transport, planning and the provision of green spaces. Air pollutants of greatest concern are particulate matter (PM), oxides of nitrogen and ozone. The most significant of these is PM, which can have either a cooling or warming effect on the climate. Those most at risk of short-term effects of air pollution are asthmatics or those with pre-existing lung or heart conditions including COPD. Chronic exposure to PM contributes to the risk of developing cardiovascular disease and lung

cancer. PM can be produced directly from sources such as combustion engines or formed reactions between other pollutants. There are "hotspots" in districts, usually due to traffic pollution or industry, where air pollution is higher than government guidelines. Borough and district councils are required to monitor and develop air quality action plans to reduce pollution. In addition, KCC and the borough and district councils are developing plans to reduce traffic flow and encourage sustainable, low emission transport.

- **Workplace, health and supply chain**

The workplace is a significant user of resources and will be most affected by the impacts of climate change, particularly with regard to vulnerable people and the ageing population. All NHS Trusts are required to consider sustainability within the planning process. Nationally, the health sector is estimated to produce 600,000 tonnes of waste per year. The NHS Sustainability Unit provides information, good practice and support for NHS trusts to reduce their carbon footprint. In addition, a Kent wide programme, Steps to Environmental Management and the Kent Healthy Business Awards, provides information and support to small and medium enterprises.

- **Natural environment**

The natural and historic environment supports health and wellbeing in a variety of ways, from provision of clean air and water and medicines, to food and natural resources to improve mental health and wellbeing. Contact with nature can help to prevent, alleviate and assist recovery from mental health problems, increase levels of physical activity and facilitate social inclusion. Across the UK, those in the most deprived communities are ten times less likely to live in the greenest areas. The Kent and Medway Nature Partnership is undertaking a needs assessment of the availability of green space in relation to health need.

2.2.26 Unintentional Injuries

Information on unintentional injuries is usually derived from national Injury Profiles by Public Health England, but these have not been updated since 2012. Thus the following information has been collected from local sources.

In Kent, local hospital admissions for unintentional injuries have increased from 18,245 in 2012-13 to 19,900 hospital admissions in 2014-15 (highest and lowest rates being 1,388 and 995 per 100,000 in Thanet and Ashford CCGs respectively). There were also 701 injury related deaths in Kent in the three years to 2014-15, equivalent to 233 per year (highest and lowest rates being 52.4 and 39.5 per 100,000 pop in South Kent Coast and Dartford Gravesham & Swanley CCGs respectively).

Admissions for 'falls due to injuries in the over 65s' – the number and rate of admissions across Kent continues to rise, with an annual increase of over 400 admissions (now up to 6,663) and a rate that is significantly higher than the England rate. Drilling down to districts

the highest rates for residents are found in Tunbridge Wells, Dartford, Maidstone and Tonbridge & Malling.

Admissions for undetermined and deliberate injuries in the 0-4 cohort for Kent are no longer significantly high. The latest rate reported in the Public Health Outcomes Framework (PHOF) shows a Kent rate of 130 per 100,000, which is much lower than the national rate of 140, although the rate remains very high in Dartford and Gravesham (176 and 171, respectively).

In 2014, Kent recorded an increase in the number of people killed or seriously injured (KSI) compared to 2013 – from 594 to 658, an 11% increase – which is now 33% above the 2020 target figure of 495 casualties. This target figure is an aspirational target promoted by KCC to its partners. The increase has been seen across the all modes of transportation. However, the rate of KSI on Kent roads remains relatively low (39.6) and broadly in line with the national rate. District wise, both Ashford (58.1) and Sevenoaks (54.7) exhibit very high rates.

Hospital admission rates for burns in under-fives were lower in 2012-14 compared with 2009-11. Hospital admission rates for falls also reduced across the county, with a significant reduction in Tunbridge Wells and Swale, where the rates were previously very high.

The 2014 needs assessment describes a wide range of organisations that deliver various prevention programmes to reduce unintentional injuries. Kent County Council's department of Highways and Transportation and other partner agencies including Kent Fire and Rescue and Kent Police perform a number of functions to prevent injuries occurring on Kent roads which are described in their casualty reduction strategy. A recent evaluation of home safety checks by Kent Fire & Rescue highlights the use of robust data to target home safety checks more effectively for the frail elderly and reduce injury. District authorities also commission Home Improvement agencies to deliver interventions which reduce the risk of injuries in the home. The Health Visiting Service uses routine visits to all families with young children to discuss safety in and outside of the home.

2.2.27 Urgent Care

The NHS Five Year Forward View (5YFV) explains the need to redesign urgent and emergency care services in England for people of all ages with physical and mental health problems and sets out the new models of care needed to do so. For adults and children with urgent care needs, a highly responsive service should deliver care as close to home as possible, minimising disruption and inconvenience for patients, carers and families.

In Kent, A&E attendances have increased in number from 2013-14 to 2014-15 by almost 12% (an extra 50,000 attendances). This increase was seen across all CCGs with Swale and SKC CCGs seeing the highest percentage rises and Thanet & Ashford CCGs the lowest. Some of these increases were probably due to changes in data recording for MIU activity into the SUS A&E dataset, so the real increase may be much smaller.

Emergency hospital admissions, rose by a modest 4% (146,000 to 152,000) – Ashford and Canterbury & Coastal saw slightly larger rises (9% and 8% respectively which relate to about 1,000 patients each) – lowest rises were for Thanet and West Kent CCGs. Most of the rise was attributed to short stay admissions of less than 48 hours (increase of 6%) compared to long stay admissions of more than 48 hours (up 1%). Margate Central and Cliftonville represent the highest rates for emergency admissions by ward, above the age of 65 years, not just for Thanet but for all of Kent.

The NHS England urgent care (phase 1) review published in 2013 emphasises five key elements for change:

- To provide better support for self-care.
- To help people with urgent care needs get the right advice in the right place, first time.
- To provide highly responsive urgent care services outside of hospital, so people no longer choose to queue in A&E.
- To ensure that those people with serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise, to maximise chances of survival and a good recovery.
- To connect all urgent and emergency care services together, so the overall system becomes more than just the sum of its parts.

2.2.28 Veterans

Local modelling suggests there are approximately 130,000 veterans in Kent and Medway, with the highest density in Thanet, Dover, Shepway, Swale and Medway. The Armed Forces Community Covenant is a voluntary agreement supporting closer working in Kent with district level boards such as the Civilian Military Partnership Board. In Dover, such a board has been set up to take forward the work of the Armed Forces Community Covenant in the district. This aims to include representatives from the military, public, private, voluntary and community sectors and is ideally placed to address veterans' issues locally. A recent survey of the Kent forces population has been undertaken, the learning from which will be shared with health partners in early 2016.

Recommendations are made in four key areas:

- Transition from Defence Medical Services (DMS) to the NHS: improve awareness of DMS record transfer to facilitate GP registration prior to discharge.
- Physical health services for veterans: raise awareness of the principle of prioritisation as set out in the Armed Forces Community Covenant.
- Mental health services for veterans:
- Build on the 2015 Kent Armed Forces Survey working with CCGs to improve services.
- Review ex-service personnel admission to improved entry to psychological therapies to establish if admittance is in line with prevalence of ex-forces in Kent.

- Raising awareness: KCC PH will support West Kent CCG, the lead commissioner for veterans' health in Kent, to work with partners to ensure the priorities in the Veterans' Needs Assessment are taken forward.

2.3 Ageing well

2.3.1 Carers

Current estimates indicate that one in ten people in the UK is a carer. According to the Census 2011, there are 151,777 people in Kent who identified themselves as providing unpaid care which is 10.4% of the population. This is higher than the regional average of 9.8%.

According to the Personal Social Services Survey of Adult Carers in England 2014-15, over a third of carers (38%) are caring for over 100 hours a week. 13.5% of carers care for 19 hours or less a week, 15% care for between 20 and 49 hours a week and almost 14% care for between 50 and 100 hours a week.

The majority of carers are of working age and the peak age for caring is 50-64, in Kent this is 55,706 or 36.7% of identified carers.

The Census 2011 reports that carers providing round the clock care are more than twice as likely to be in bad health, than non-carers. The pressures of caring can take a toll on carers' physical and mental health. A recent survey report by Carers UK (state of caring 2015) identified that 54% of carers have suffered depression because of their caring role; carers also felt more anxious (77%) and more stressed (83%) because of their caring role.

The Care Act 2014 strengthens the rights and recognition of carers in the social care system including, for the first time, giving carers a clear right to receive services.

Recommendations: health and social care commissioners should pay particular attention to:

- Supporting carers of those with dementia
- Supporting carers who are elderly and/or have their own health needs and for whom the caring role is particularly intensive, for example for those living with the person they care for or spending over 100 hours a week caring
- Supporting carers within new emerging black and minority ethnic (BME) communities
- Ensuring easy access to information, advice and guidance for both known and unknown carers, particularly in deprived areas
- Support for working age carers
- Creating capacity in the social care system to support respite, short breaks, and hospital discharge.

2.3.2 Dementia

The number of people living with dementia in Kent can be estimated using age specific rates, and applying this to the population of Kent. Using this method, it is estimated that the prevalence of dementia in Kent is 1.34%, which equates to 20,496 people living with dementia in Kent.

Undiagnosed dementia is an important issue. This is highlighted by the discrepancy in the estimated prevalence and the prevalence indicated by practice records, which is 0.78%. However, although there is a gap between diagnosed and expected dementia, this gap has decreased since 2013-14 and it is now estimated that 57.7% of people living with dementia have been diagnosed as such, compared to 44.3% in 2013-14. There remains work to be done to meet the government target of 67% diagnosis rate.

The highest expected prevalence of dementia is seen in Shepway, Thanet, Dover and Sevenoaks.

There is a clear link between risk factors for chronic disease and the development of dementia. This link should be emphasised at both a population level, through inclusion of dementia in strategies to prevent non communicable diseases, and at patient level when counselling individual patients about the risk of dementia. Population level initiatives to decrease the prevalence of dementia include smoking cessation and alcohol reduction interventions, and promotion of healthy weight and physical activity.

For patients diagnosed with dementia, early secondary intervention to prevent deterioration and support wellbeing provides help to individuals living with the disease/disorder and their carers. It is estimated that interventions such as specialist support at home can reduce demand for care home placements by up to 28%.

More than 85% of patients living with dementia have at least one other long-term condition, and more than one in four patients have five or more additional long-term conditions. Therefore patients living with dementia have substantial physical and mental health needs. Additionally, there is a lack of specialist end of life care services which support people living with this condition.

Kent Fire and Rescue are training all their staff to be Dementia Friendly and offer advice, referrals and equipment to these patients to ensure that they can live safely and independently for as long as possible.

Recommendations:

- Ongoing efforts should be made to increase diagnosis of dementia to facilitate early intervention.
- Support and treatment of people living with dementia will be improved through integration of health and social care services. A shared platform for communication between services is an integral aspect of this.

- There should be a multi-sectoral approach to supporting people with dementia, which includes voluntary sector providers. There should be ongoing support of Dementia Friendly Kent initiatives and monitoring of their impact.
- End of Life care pathways for patients with dementia should be agreed.

2.3.3 End of Life Care

The majority of deaths in Kent were caused by chronic conditions including cancer (28%), respiratory disease (16%), coronary heart disease (11%), stroke (9%) and other circulatory diseases (9%).

Despite preferences that suggest otherwise, the acute hospital remains the most frequent place of death (46%) for the roughly 13,800 patients that die every year in Kent. This is approximately 1% of the county's population. Although it has been steadily reducing, the disparity between preferences of place of death and the reality remains stark The End of Life Care Strategy (2008) initially set out the original direction of travel to provide all adults nearing the end of life access to high quality care and to support people in realising their choices and preferences for care. Survey data suggests that many people would, given the choice, prefer to die at home and few wish to die in hospital.

In terms of future need, there is an expected increase in the number of cancer and non-cancer deaths due to demographic change. This will have implications on the EoLC service and adequate planning needs to be undertaken to deal with this.

A major opportunity to address some of the key issues outlined above is through adoption of the new Long-term Conditions agenda that incorporates the themes of risk stratification, integrated teams and self-care. The vision is for a unified data hub that integrates activity across all health and social care. A fully functional system will enable early identification for those at risk of death and enable more accurate EoLC planning across a population, ensuring health and social care are better co-ordinated and integrated with each other.

Recommendations:

- Improving palliative care registers to find the "one per cent".
- Sharing an EoLC register in primary and secondary care to ensure health and social care staff identify these people early.
- Training of frontline staff to identify and meet the needs of this population group.
- An increase in capacity due to increasing cancer deaths.
- Developing the service to meet the needs of non-cancer patients.
- Ensuring adequate support is available to meet the EoLC needs of an emerging cohort with dementia.

2.3.4 Excess Winter Deaths

An estimated 43,900 excess winter deaths occurred in England and Wales during the winter period of 2014-15, a ratio of 27% more deaths in the winter period compared to the non-winter period. This is estimated to be the highest number of excess winter deaths since

1999-2000. Local estimates indicate that the Kent figures for this period are comparable to the national trend. Excess winter deaths in Kent are measured as a ratio of the number of winter period deaths compared to non-winter deaths over a three year rolling average period. The Kent ratio for the most recent three year period 2012-13 to 2014-15 is estimated to be 21.2%, compared to 16.5% excess winter deaths during 2011-12 to 2013-14.

Kent has continued to develop partnership referral pathways to try to reach those most at risk in cold weather. Emergency support is available at a population level and Public Health have co-funded housing retrofit interventions with the Kent County Council Warm Homes programme, to provide sustainable interventions such as insulation and heating repairs for those over 65 with a long-term health condition, particularly respiratory disease and circulatory conditions.

Kent Fire and Rescue have trained their home safety officers to ensure they recognise the signs to look for and what information to provide. They have produced postcards with thermometers to signpost people to get support.

During 2016 partnerships will need to be strengthened to ensure:

- More equitable primary care engagement.
- Improved communication between public sector, the voluntary and charitable sectors.
- Joint funding opportunities are explored to improve population approach.

2.3.5 Falls and Fractures

Falls prevention has recently seen some changes with the Kent wide commissioning of postural stability (PS) community classes in order to address falls in the older population (age 65 and over) who are most at risk. A review of current services which have contact with older adults across Kent has been undertaken and a falls management service has also been implemented.

The Department of Health's Falls and Fractures: Effective interventions in health and social care (2009) states "Preventing older people from falling is a key challenge for the NHS and local authorities. It is not the preserve of one agency as the consequences of a fall and resultant fragility fracture cut across all local agencies working with older people." This is evident across Kent. Kent County Council and local organisations working with older people, including statutory and voluntary service providers, have come together as a part of the solution.

The key achievements have taken place. Public health has implemented a single point of referral for postural stability classes to collate and monitor referrals. This service sits within the public health department in Kent County Council. A pathway has been developed working with local referral units (LRU), the Area Referral Management Service (ARMS) and falls prevention/management services. Where applicable, all referrals, both from the general public and other stakeholders, go directly to Kent Public Health

Department. Referrals are then triaged accordingly to either postural stability classes or directly to a falls prevention service for a more comprehensive assessment; this could involve housing and medication reviews.

Over the last two years, collaborative work with CCGs across Kent has commenced on the rehabilitation aspect of falls prevention, engaging with other clinical practitioners (e.g. pharmacies, opticians, GPs) and local organisations. The setting up of a falls service as identified within the Falls Framework 2013 has seen the following results:

- West Kent CCG have in place a falls prevention/management service.
- Dartford, Gravesham and Swanley (DGS) CCG has commissioned a falls service which sits within the intermediate care team.
- In East Kent, a task force group has been established which includes the following CCGs: Ashford, Canterbury, South Kent Coast and Thanet to review services across the East. A Frailty Pathway has been drafted focusing on falls; however, this is still work in progress.
- Kent Fire and Rescue staff undertaking safe and well visits are trained to recognise falls issues and offer lots of practical advice to reduce the risk. They are also working with the Integrated Care Equipment Service and have trained two of their staff as trusted assessors as a pilot in the Margate area. If this is successful they will roll this out across Kent.

Public health has commissioned the following providers to deliver postural stability classes across Kent:

- in the North, Voluntary Action Maidstone
- in the West, Good Neighbour
- in the East, Kent Community Health Foundation Trust.

KCC Public Health and DGS CCG are working, together with Kent Fire and Rescue Service's senior management teams, on a trial on falls reduction work which will link in to the development of the KFRS Stay Safe and Warm visit.

The majority of falls result in hip fractures. Causes of a fall are often an interaction of medical and social reasons such as urinary tract infections, dementia, pneumonia and medication usage as well as poor housing conditions, lack of equipment and adaptations or lack of carer support. The number of falls admissions are still listed as one of the highest Ambulatory Care Sensitive (ACS) conditions within urgent care.

Preventing falls requires a multiagency approach and falls prevention is a public health issue in Kent. Actions to reduce the number of older people who fall and support those who do to regain their mobility and independence are now being reflected in many local programmes and services. Although some progress has been made to date, there is still a wide range of opportunities to bring this work together in a more consistent way through the commissioning and development of the falls framework. Case finding in primary care mainly

concerns proactive case finding by GPs of patients with a past history of falls and fractures who have not yet been properly assessed.

All partners in the health and social care system have a role to play in reducing the incidence of falls at a local level. KCC Public Health should continue working and engaging with partners, pharmacies, GPs, CCGs, Kent Fire and Rescue Services, voluntary organisations and other stakeholders to ensure there is an integrated approach towards having preventative and reactive measures in place.

Recommendations:

- Commission acute care fracture liaison services based in acute care trusts, identifying and assessing elderly patients admitted for hip or fragility fractures for future risk of repeat fractures, followed by regular osteoporosis treatment. (This function could be supported by community pharmacists via the Medicine Use Review (MUR) service in order to improve the compliance rate of osteoporosis medication.)
- Commissioners should revisit the possibility of South East Coast Ambulance Service (SECAMB) working more closely with other health and social care professionals (either through existing integrated pathways or joined up services) in ensuring that elderly fallers who are not conveyed to hospital are properly screened for risk of falls and referred onward for specialist assessment and management.
- In order to further reduce incidence of falls, relevant commissioners need to:
    - Develop a campaign with the aim to support the local population in engaging with preventative interventions, particularly those in the 65+ age group and those 50 years and over with multiple conditions.
    - Work closely with care homes in order to understand falls issues in residential care and also within the acute/hospital environments.
    - With the postural stability classes now across Kent, public health commissioners should ensure monitoring, feedback and evaluation of services is carried out to inform further programmes that can engage with falls prevention.
    - Train front line staff how to identify individuals who might be at risk of a fall.
    - In the forthcoming revised needs assessment, the role of housing as part of the Kent Falls Framework is being reassessed to strengthen their working with other stakeholders.

2.3.6 Stroke and TIA

This condition is the third highest cause of death in the UK and the leading cause of serious disability. Stroke has many modifiable risk factors: high blood pressure, high cholesterol, physical inactivity, poor diet, excess weight, smoking, alcohol, diabetes and atrial fibrillation. As such, public health interventions have a significant role in reducing stroke incidence in

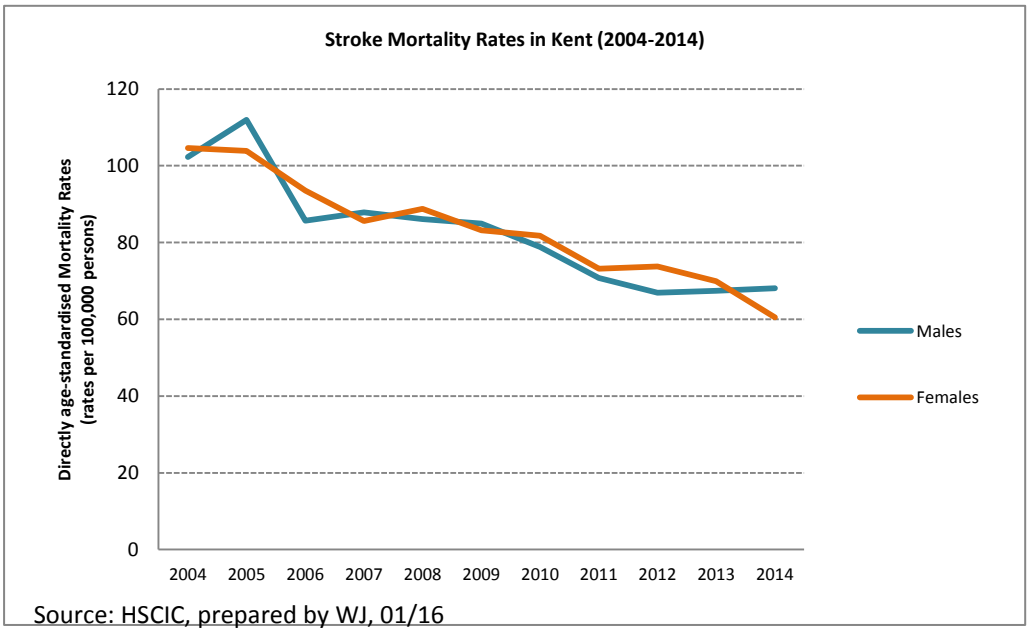
Kent. For example, the Health Checks programme is a systematic way of identifying and reducing cardiovascular risk.

Stroke incidence escalates with increasing age, and Kent is facing an ageing population with a growing proportion of the population over 65 years of age.

Recent stroke incidence modelling and forecasting, however, (using hospital episode data) found that the number of first strokes occurring in Kent is expected to remain at roughly current levels over the next 10 years, despite the aging population. This is thought to be due to better risk management and primary care prevention. Stroke mortality rates have in general been decreasing in Kent over the last 10 years.

As more people are surviving stroke, the prevalence of stroke in Kent is increasing. Between 2006-07 and 2013-14, the prevalence of stroke increased by 1.34% across Kent and Medway compared to 0.94% for England. Stroke prevalence is higher in East Kent especially in the Thanet and South Kent Coast CCG areas and there is a lower stroke prevalence in North Kent, DGS and Swale CCGs. This sub regional variation is due to differences in population demographics and age profiles.

Figure 10:



Source: HSCIC, prepared by WJ, 01/16

There have been many advances nationally in stroke care which account for the overall reduction in stroke mortality:

a Greater awareness amongst the general public of stroke symptoms and the need to seek immediate medical attention due to the 'FAST' campaign, which is ongoing.

b Better acute stroke care in dedicated stroke units which provide expert specialist and multidisciplinary clinical assessment, rapid imaging and therapeutic intervention, including 24/7 delivery of thrombolysis.

c Rapid access transient ischaemic attack (TIA) clinics where high risk patients are seen within 24 hours, and all patients within a week. A TIA or "mini stroke" is when stroke symptoms resolve within 24 hours, indicating a high risk of a subsequent stroke.

As more people are surviving stroke, an important role is placed upon post stroke care. This includes services such as early supported discharge (within 10 days) and multidisciplinary community rehabilitation services. The South East Coast Strategic Clinical Network (SCN) recently published guidance for commissioners on post stroke care (Life After Stroke http://www.secscn.nhs.uk/files/7614/2183/7469/11LaS.pdf) to better support those who have had a stroke to get back to living a full and active life and reintegrating within society.

The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by auditing stroke services against evidence based standards and national and local benchmarks. The map below (Figure 11) shows that when accessed over 01/16 Kent's stroke providers score quite well relative to the rest of the South East Coast SCN, with high organisational scores in Ashford, Canterbury and Margate. There are low scores in Maidstone and Dartford. The highest scores nationally are found in London, where centralised, hyper acute stroke units were first pioneered.

Figure 11: Stroke Providers Organisational Scores

Source: RCP SSNAP Domain Map,

Recommendations:

a Public health commissioners should continue to commission services that promote healthier lifestyles, smoking cessation, and cholesterol and hypertension management to reduce stroke risk factors.

b Service commissioners should commission post stroke care to ensure that stroke patients can recover as best as possible and minimise the impact of disability on their life and wider society.

3. Social Care

Kent County Council Social Services is in the process of progressing its transformation agenda to provide high standard services based upon the needs of individuals, with recognition that the levels and types of services will vary significantly between individuals within defined adult and children's social care groups.

Social Care services in particular are facing four huge challenges:

1 People want better quality and choice in the services they use.
2 The population is living longer with complex needs putting further demand on social care.
3 The financial climate is imposing massive constraints on local authorities.
4 Services are delivered jointly with the NHS and other partners.

3.1 Adult Services

By 2021 the population of Kent and demand on services will have increased. The annual local account document highlights that adult services currently support 34,424 adults through a variety of services.

Table 5:

Supported Adults Age Ranges	Numbers
18 - 64	12,522
65 - 74	4,342
75 - 84	7,400
85+	10,160

Source: KCC Adult Social Care Services 2015

The combined figure for those aged over 65 (21,902) represents 1.35% of the Kent population and is lower than the national average.

- 12,356 receive home care support (0.83% of the county population: lower than the national average)
- 4,064 in permanent residential placement (2014-15)
- 1,242 residents in nursing homes (2013-14)
- 2,660 clients received a day care service (0.18% of the county population: lower than the national average)
- 23,971 people received an assessment
- 19,583 clients had their needs reviewed
- 19,216 carers were assessed
- 26,329 clients have a physical disability
- 3,545 have a mental health issue
- 4,550 have a learning disability.

Of the 12,522 adults aged between 18 and 65 years, 99.6% have a learning disability, a mental health issue or a physical disability. In terms of referrals, 2,440 were referred to sensory services and 403 to autism services.

There has been an increase of 120% in relation to numbers of adults receiving telecare services. An enablement service was received by 8,131 adults, compared to approximately 8,222 adults in 2013-14. Of those who used enablement, 84.1% were able to return home due to the support provided, which is an increase on 2013-14.

The adult population in Kent (18+) is likely to increase by 5.6%, between 2015 and 2020. These changes will play a huge part in shaping the future of adult social care, both nationally and locally. There will be significant growth in the numbers of people aged over 65 and 85 and an increased prevalence of people living with dementia. Earlier diagnosis and better treatment will mean that people will live longer with long-term conditions and people with a learning disability will also live longer.

With the demographic challenges of our aging population, support services for older people are the biggest area of growing demand. There is a need to ensure that there is a good range of accessible and supportive services within communities that enable people to remain independent and connected to their communities. The service has pressures around various client groups such as carers, dementia, mental health, learning difficulties, physical disability, sensory impairment, autistic spectrum conditions and domestic abuse. During 2014-15, 3,273 safeguarding referrals were received in comparison to 2013-14 when there were 3,176. In addition to this, another 3,382 safeguarding contacts were received but did not meet the criteria to be referred for investigation.

3.2 Initiatives

Kent is one of fourteen national Integration Pioneers. The Department of Health has chosen KCC to provide joint services with health sooner than other local authorities. Significant benefits are already being identified within the programme; however they will look and feel slightly different in each area.

Some examples of success to date include:

- the Integrated Discharge Team in North Kent
- West Kent Integrated Rapid Response Service
- Ageless Thanet: making Thanet a great place to grow old.

Social Services are taking part in a national initiative designed to improve access to general practice and develop new ways of providing GP services. Practices taking part in the trial are piloting a range of options to make services more accessible to patients. These include a new, extended access GP service launched in October 2015 at the Royal Victoria Hospital in Folkestone. Highly trained minor injuries nurses support the GP service and GPs now have full access to patients' records. Folkestone Walk-in Centre became a Minor Injury Unit, focusing on the treatment of injuries such as suspected fractures of arms or lower legs,

minor burns, bites and stings for everyone aged 12 months and above. Deal Minor Injuries Unit extended its opening hours and will continue to treat minor illnesses.

South Kent Coast is one of nine pilot sites nationally to test personal health budgets for people other than those needing continuing healthcare. Integrated personal budgets have been offered to patients to enable them to take control of their health and social care support and buy services that meet their needs.

The Kent Social Care Accommodation Strategy provides clarity regarding the current levels of housing and care home provision across Kent. It identifies where there are gaps in provision, considers the future housing and care home accommodation needs of each of the adult social care client groups, and identifies how and where these needs will be met.

Appendix A

1. What is the JSNA?

The aim of the Joint Strategic Needs Assessment (JSNA) is to identify the health and social care needs of the local population in order to support local organisations to plan, commission and deliver the best possible services.

There is a legal duty under the Health and Social Care Act 2012 for local authorities and clinical commissioning groups (CCGs) to jointly undertake the JSNA. CCGs and local authorities, including Directors of Public Health, will each have an equal and explicit obligation to prepare the JSNA, and to do so through the arrangements made by the Health and Wellbeing Board. The board will then develop the Joint Health and Wellbeing Strategy (JHWS), based on the assessment of need and recommendations outlined in their JSNA.

JSNAs should support health and social care commissioning decisions and the development of the local Joint Health and Wellbeing Strategy.

The Kent Approach to the JSNA involves the development of six products (see Appendix B) which describe the needs of the population at different levels:

- Kent County Council (which this document represents)
- 7 clinical commissioning groups (CCGs)
- 12 district authorities

The key objectives for producing a JSNA are:

- To coordinate strategic direction, effort and resource commitment of the range of public, private and voluntary/community sector organisations that work to the common goals of improving health and wellbeing for the population of Kent.
- To ensure that resources are focused on achieving maximum impact on improving the health and wellbeing of the people of Kent specifically targeting those who are in greatest need.
- To maintain a focus on health improvement and prevention and ensuring efficient use of available resources.

This document summarises the needs at the Kent county level, with brief descriptions at CCG and district authority level.

1.1 Who should use the JSNA?

The JSNA will be a valuable tool for:

- Kent County Council
- district authorities
- clinical commissioning groups
- providers of health and social care
- the voluntary sector and other case makers.

Why is it relevant for Kent County Council?

The JSNA supports and underpins implementation of Kent County Council's strategic statement "Our Vision":

- children and young people in Kent to get the best start in life
- Kent communities feel the benefits of economic growth by being in work, healthy, and enjoying a good quality of life
- older and vulnerable residents are safe and supported with choices to live independently.

It also supports development of a more effective and responsive local health and care system, shared understanding and shared ownership leading to agreement of priorities and collective action. Some historic examples of the economic development in Kent involves programmes such as the Marsh Millions scheme and the LEADER programme for rural businesses both of which stimulate employment and influence the local people's health and wellbeing.

Why is it Relevant for District Authorities?

District authorities have a key primary prevention role in minimising the effect of poor housing, poor environment (e.g. noise, air and water pollution) and transport (for example road safety measures to reduce accidents) all of which have an impact on health and social care outcomes.

District authorities also provide health and wellbeing services, in particular for smoking, alcohol, physical activity, healthy weight. They therefore need to adopt a high risk approach and work more closely with primary care and acute care organisations to ensure that services are targeted towards the most vulnerable and at risk groups to achieve optimum effectiveness. This can be done by ensuring NHS based care pathways for long-term conditions are integrated and include such services, for example prescribed exercise programmes for the elderly to reduce falls and fractures, Healthy Weight Care Pathway for adults and children who are clinically obese or overweight for the prevention of diabetes.

The policy document, The district council contribution to public health: a time of challenge and opportunity (Buck D, Dunn P 2015), gives strategic public health direction to district councils and further argues that they have an important role to play in supporting social

capital by strengthening social networks and community-centred approaches to health, potentially through enabling greater volunteer involvement in health care support. These approaches have been shown to have strong and direct links to health, as powerful predictors of mortality in older populations, as common lifestyle risks, such as moderate smoking, obesity, and high cholesterol and blood pressure. They are also important in determining or averting health behaviours as well as resilience to and recovery from illness.

Why is it Relevant for Clinical Commissioning Groups?

CCGs as commissioners can transform quality, clinical and cost effectiveness of health services, and make the shift to out of hospital care.

General practitioners (GPs) are the first and critical point of contact for patients. Reduction in practice variation will result in better health outcomes and will contribute to reducing the gap in health inequalities for the population of Kent. For example, case finding of people at risk of heart disease, stroke, diabetes and chronic kidney disease through NHS Health Checks will result in people being identified earlier and treated sooner, reducing the risk of ill health and death associated with late diagnosis. Brief interventions for smoking, alcohol and healthy weight will reduce the number of people with long-term conditions.

Why is it Relevant to Providers of Health and Social Care?

The NHS 5 Year Forward View recommends taking decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally, but with some services in specialist centres, organised to support people with multiple health conditions; not just single diseases. No one size fits all care model can apply, but a range of different ones, such as multi- speciality community providers (MCP), primary and acute care systems (PACS), and smaller hospitals working in partnership with other specialist hospitals, can provide more local services. The JSNA needs to look at evaluation of outcomes for these new care models and reflect on how population health and wellbeing has improved over time as highlighted by the case study below.

Case Study: Application of the Children and Adolescent Mental Health Services (CAMHS) Health Needs Assessment / JSNA Chapter to Practice

The learning and recommendations from the CAMHS Health Needs Assessment and JSNA chapter have been used to inform the strategic priorities of the Emotional and Mental Health Strategy and the system remodelling work that has resulted from it. The learning was shared in detail with the multiagency sub-group leading the development of the strategy and action plan. As a result, a whole systems response has been taken, ensuring clarity of service response at each tier of need and clarity as to how the system as a whole needs to work together. The needs assessment also estimated the level of provision required at each tier. As a result, there has been work to increase Tier 1 and Tier 2 provision. The issues with informatics identified in the needs assessment have also been addressed. The multi-agency group have agreed and resourced an integrated approach to outcomes and data development which will facilitate whole systems oversight and enhanced analytics going forward.

1.2 History of Kent County JSNA

A JSNA has been produced in Kent since 2006, initially broadly divided into two documents, Adults and Children, which were both updated in July and December 2011 respectively. The Overview Report of 2012 integrated the approach into six areas, health inequalities, lifestyles, children, adults, delivering QIPP (Quality, Innovation, Productivity, Prevention), and finally social factors and population groups.

During 2015, the county council sponsored a JSNA workshop which attracted a broad range of partner's views about the JSNA and the associated process. it was generally felt that this feedback provided sufficient evidence to frame a suite of recommendations to support the JSNA process and engagement with our partners. These actions centre around areas that will support the awareness and use of the JSNA, the editorial quality of the finished product(s) and, if necessary, the governance of the process. These actions have been embedded into this JSNA Overview Report and subsequent process.

The current iteration primarily focuses upon three areas: Starting Well, Living Well and Ageing Well; with an additional theme around the important issue of User Engagement. The approach is supported with overviews of district and CCG locality profiles.

The JSNA includes many health needs assessments which are undertaken each year on specific topics such as mental health, children in care, housing, and carers. More than 40 needs assessments have been carried out and refreshed in Kent since 2008, exploring in depth the health and social care needs, gaps in service provision and levels of unmet need. These have been developed and summarised in a standardised format available on the Kent and Medway Public Health Observatory website, http://www.kpho.org.uk/joint-strategic-

needs-assessment. In addition, key population indicators are also presented in (district authority -based) Health and Social Care Maps across eight themes (http://www.kpho.org.uk/health-and-social-care-maps).

2. Strategic Framework

The JSNA is positioned to support partners and other stakeholder's strategic policy drivers and can therefore act as a powerful and flexible resource for partners to use to aid their planning functions and commissioning activity. In the current climate there is a raft of these policy-influencing drivers within which the JSNA can assist the relevant leaders and their organisations to prioritise their investments to maximise appropriate health and social care investment to whichever community they serve.

2.1 Placed Based Systems of Care

The report, Place-based systems of care: A way forward for the NHS in England (Ham C, Alderwick H 2015), outlines that the NHS is facing growing fiscal pressures and is developing new care models designed to deliver services more appropriate to the changing needs of the population.

It is seeking to tackle these challenges in the context of organisational arrangements that are more complex and fragmented than at any time in its history. The question is how to adapt these arrangements and make them fit for purpose.

The report argues that providers of services should establish place-based 'systems of care' in which they work together to improve health and care for the populations they serve. This means organisations collaborating to manage the common resources available to them.

The approach taken to developing systems of care should be determined by NHS organisations and their partners, based on a set of design principles that is outlined in their paper (Ham C, Alderwick H 2015). These principles include developing an appropriate governance structure, putting system leadership in place and developing a sustainable financial model.

Government and national bodies in the NHS should work to remove the barriers that get in the way of working in place-based systems of care and should themselves work in a co-ordinated way to support the development of these systems. This includes creating stronger incentives for systems of care to evolve to tackle current and future challenges.

Fundamental changes to the role of commissioners are needed to support the emergence of systems of care. Commissioning in future needs to be both strategic and integrated, based on long-term contracts tied to the delivery of defined outcomes. Scarce commissioning expertise needs to be brought together in footprints much bigger than those typically covered by CCGs, while retaining the local knowledge and clinical understanding of general practitioners (GPs).

Systems of care hold out the prospect of NHS organisations developing services that are financially and clinically sustainable and putting in place new care models that are able to improve the health and wellbeing of the populations they serve. The alternative is for each NHS organisation to adopt a "fortress mentality" in which it acts to secure its own future regardless of the impact on others.

The argument of this paper is that collaboration through place-based systems of care offers the best opportunity for NHS organisations to tackle the growing challenges they are facing.

The JSNA products are well suited to support this integrated approach to care. Coupled with a whole systems intelligence framework, they can provide the platform to address these complex issues.

2.2 NHS Five Year Forward View and Planning Guidance 2016/17 and Beyond

The Forward View (NHS England et al, 2014) sets out a clear direction for the NHS's need to change and sits alongside the Planning Guidance for 2016/17 - 2020/21 (NHS England et al, 2015). It describes what the future may look like, involving a new relationship with patients and communities which involves prevention, empowering patients, engaging communities and viewing the NHS as a social movement.

It describes potential new models of care, arguing that one size does not fit all and that there are requirements for new care models. It further describes how the NHS will support local co-design and implementation. This place-based approach acknowledges that the current deficits are no longer a provider problem and that to maintain a sustainable financial model requires commissioners, providers, and local authorities to work together.

The NHS will back diverse solutions and local leadership, create aligned national NHS leadership and support a modern workforce. They will exploit the information revolution, accelerate useful health innovation and finally will drive efficiency and productive investment.

In the current financial environment, the focus for health and social care services is on those in poor health or greatest need; if the decrease in healthy life expectancy continues, more people will be projected to require health and social care over the next 5-10 years. However, there are significant opportunities for the rest of the public and voluntary sector to focus on reducing the risk of people becoming ill or having increasing need; making use of an asset approach involving CCGs, Kent County Council and the districts; focusing on prevention, particularly working with the middle ages (40-64 years) adult population to promote healthy ageing; to keep people active and eating healthily to reduce future risk of disease or to support active management of health conditions to improve outcomes and help people retain independence for longer.

2.3 Growth and Infrastructure Framework

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

needed to support this growth. It was finalised following its consideration by Kent County Council in July 2015 and other public sector Kent leaders in September 2015. The full GIF can be accessed via the following web link: www.kent.gov.uk/gif.

As part of the infrastructure to support growth in Kent and Medway, the GIF provides evidence on the provision of healthcare and social care capacity across the area – both current provision and provision that would be required to support the planned housing growth to 2031.

Primary healthcare required to support population growth to 2031 was mapped and the analysis of the provision of GP numbers identified that there is a lack of capacity in proposed growth areas. 146 additional GPs and associated premises of 24,100 square meters and 121 additional dentists and associated premises of 6,000 square meters will be required.

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

The GIF maps current social care provision across Kent, including provision for people with learning disabilities; people with mental health needs; older people; and people with physical disabilities. The following capacity issues were identified in the following client areas: learning difficulties, mental health, older people, physical disabilities.

Costs and future provision requirements are estimated on the basis of the Social Care Accommodation Strategy (Kent County Council 2014), which sets out the forecast change in demand for the full range of care clients. This analysis has highlighted the need for considerable investment in older people's nursing and extra care accommodation and also supported accommodation for clients with learning disabilities.

There are limitations on the data used for the GIF, but there is a clear need to refine the picture of health and care infrastructure to meet future growth in the next and future iterations of the GIF. The GIF authors note that whilst the findings of the GIF should be read with caution, they highlight a critical challenge in funding health and social care provision to meet future demand. In particular, the GIF has highlighted challenges in such provision in growth areas where the viability is more marginal.

2.4 A Whole Systems Intelligence Approach

The case has previously been made for the development of a whole systems intelligence approach, focussed on the analysis of linked person level data as opposed to organisation level. The objective of this shift was to develop more tangible insights relating to the multiplicity of care inputs at an individual level, their continuity and duration over time. Where relevant, such analyses would account (by segmentation) for the underlying predictors and determinants of health and well-being.

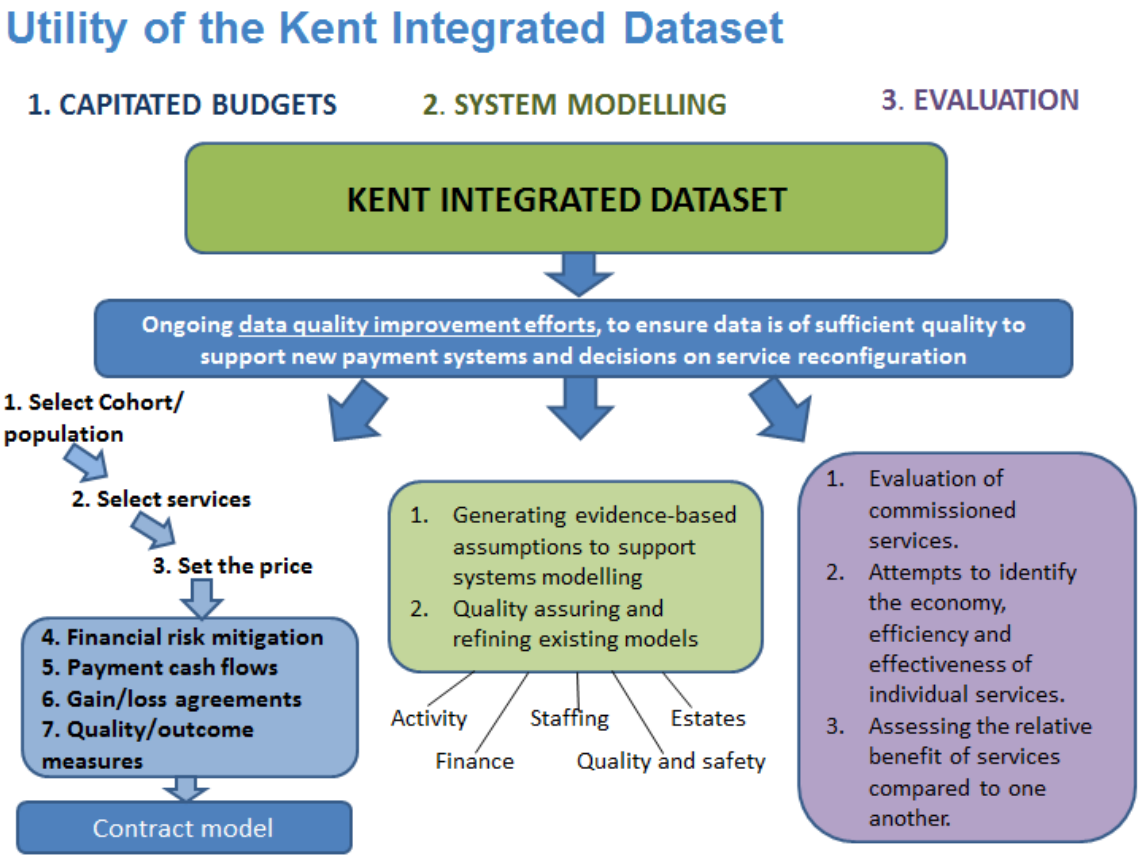
There is currently a poor understanding among most commissioners around the important role of informatics towards integrated commissioning, particularly for strategic and planning purposes. Most commissioner expectations are orientated around collection and collation of raw service data for performance and contract management/monitoring, and to construct a set of Key Performance Indicators. Very little emphasis is given to the application of that raw data for planning and epidemiological purposes, where it can be linked at a person level to other datasets from services across the economy.

Much of the data used in this report is based on the JSNA core dataset of indicators such as hospital episode statistics, Office for National Statistics deaths data, number of looked after children etc., but these are headline indicators. There is no systematic approach to link the raw data beneath these indicators to gain more insight of the complex interrelationships and multiple risk factors that influence health and wellbeing.

Confusion also exists regarding type of data to be linked. For clarification it is routine administrative data that services collect for contractual purposes. Such data is usually structured, coded, and follows an organisational, national or international classification system. At the moment, this is distinct from care record / planning information from different clinical and information systems for direct care purposes. Such information may be unstructured and only accessible via an interoperability gateway, where available, to health and care practitioners. Clarity is further confounded by many of the datasets collected by organisations not following a standardised data dictionary. This is necessary for improved data consistency, completeness and quality of coding.

The new and emerging Kent Integrated Dataset (KID) links person level data with the aim of supporting commissioning of integrated care.

Figure 1: **Kent Integrated Dataset (KID)**



The Kent Integrated Dataset (KID) will build on the Long Term Conditions Year of Care Programme which ends in March 2016. The KID links person level data with the aim of supporting commissioning of integrated care.

The project began in 2013 building on earlier research. It demonstrated that it was possible to identify people with complex care needs who periodically enter a "crisis" leading to emergency hospital admission. The project set itself the task of creating a methodology to identify these people prior to this crisis and to provide interventions likely to prevent the crisis occurring in the first place. The research indicated that this could be achieved through identifying patients with a combination of multiple long-term conditions and a rising risk score using a risk stratification tool.

At this point Kent entered the Long Term Conditions Year of Care Programme with the aim of developing a capitated funding model for this cohort of patients. This required the creation of a linked dataset containing cost and activity data. The linked dataset is used to select the cohort of patients to be targeted by preventive interventions and also identify the cost of the services this cohort currently uses. This information can be used to build a capitated budget for use in commissioning integrated care services aimed at preventing emergency admissions to hospital. Capitated budgets are a new method of paying for health and social care in which a per capita payment is made for a group of health and care services to a defined cohort of patients.

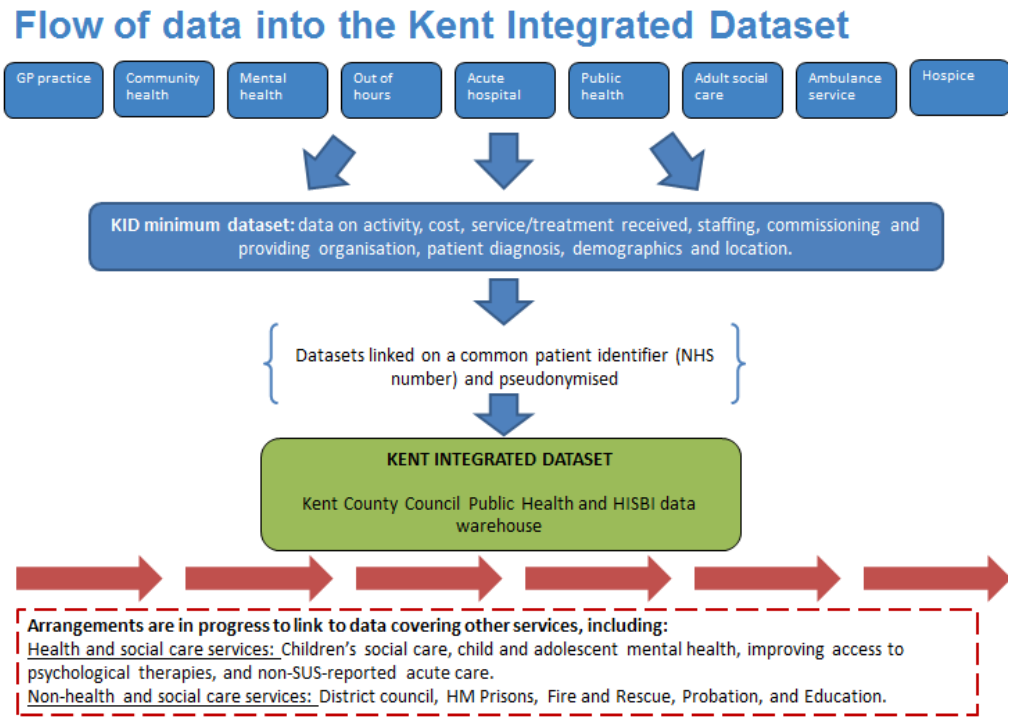
The first step was to establish a legal basis for care providers to share information. Working in partnership with a designated data warehouse run by Kent and Medway Health Informatics Service (KMHIS), KCC Public Health identified a solution, using NHS number as the means to link data. This data would then be pseudonymised within the data warehouse to prevent identification of individual patients. This required the application of a technical solution known as a "one-way hash" pseudonymisation tool recommended by the national Information Governance Alliance.

The linked dataset has further uses. A set of standard reports provides a multi-morbidity profile indicating which conditions most commonly occur together. This helps commissioners and practitioners to plan and target services.

Further data is being added to the dataset to enable evaluative studies to be conducted; looking at the impact of different interventions. For example, fire and rescue data has been added to the dataset to enable an analysis of the impact of Home Safety visits on hospital admissions using matched cohorts.

The KID will be funded by KCC and CCGs to support the development of integrated care initiatives using capitated funding and once these services are fully operational, it will evaluate their impact.

Figure 2: Flow of data into the Kent Integrated Dataset



Once a legal basis was established, KMHIS was able to collect and link data from 12 organisations and a significant number of GP practices across Kent to provide a profile of health and social care services used by people with long term conditions. KMHIS had

previously developed a risk stratification tool to support GPs in identifying patients at risk of hospital admission. This tool was applied to the Year of Care (YoC) linked dataset. Those patients with two or more long term conditions and a recently rising risk score were classified as the YoC patients. This cohort showed significantly higher consumption of health and social care resources than the general population. As a result, a group of around 30,000 people across Kent has been identified as the target for interventions aimed at preventing hospital admissions. Capitated budgets can now be calculated for these individuals, banded according to the number of long-term conditions. These funding tools are now being reviewed with CCGs with a view to using them to fund integrated care organisations and MCPs. It is anticipated that the KID will be used to build shadow capitated budgets across East Kent from 1 April 2016.

2.5 Developing an Asset Based Approach to the JSNA

Traditionally JSNAs have been developed using a deficit approach by focusing on problems, needs and deficiencies in communities, such as deprivation and illness. The information provided meant that commissioners were likely to design services to fill the gaps and fix the problems. This can lead to individuals and communities feeling disempowered and dependent, becoming passive recipients of services rather than active agents in their own and their families' lives.

JSNAs need to contain both quantitative and qualitative data ("community voice"), in order to become more usable by commissioners and to offer a strong picture of the needs and strengths of the communities it serves.

Since the publication of the previous JSNA, support has been growing and developing for CCGs and local authorities to bring an asset approach to the development of the JSNA. This asset based approach provides a new way of challenging health inequalities, valuing resilience, strengthening community networks and recognising local expertise. Using such an approach can allow commissioners to re-evaluate how services are delivered in a locality and to build upon the strengths that already exist.

The report, A glass half full: how an asset approach can improve community health and wellbeing (I&DEA 2010) sets the strategic context and maps how communities and local leadership can develop the assets approach as an important strand of tackling health inequalities. Assessing assets alongside needs will give a better understanding of communities and help to build resilience, increase social capital and develop a better way of providing services.

Kent Sheds - an asset based approach

Public Health in Kent County Council (KCC) has been supporting local individuals, community groups and organisations to establish a number of Shed projects across the county as part of the Kent Mental Wellbeing Investment Programme. The Kent Shed concept and brand was developed with the help of Activmobs (a community insights organisation), Groundwork South (a voluntary sector organisation), KCC representatives from both Policy and Public Health and, most importantly, local men, in 2013. It had two main objectives, the first of which was externally funded: 1) to support ex-military men to reintegrate and 2) to provide accessible opportunities to combat social isolation for men of all ages in Kent.

The project improves both physical health and mental wellbeing of participants, benefits local communities and supports men in developing skills for employment. A Shed is commonly a community-based location (though some have been 'virtual' sheds where people meet in different places) that offers:

- A safe and welcoming environment where individuals can feel comfortable discussing their problems with other people and then be referred to further support
- Sustainable activities and a social environment for these individuals to improve their wellbeing.

There is real value in Sheds tackling isolation - men consistently report a strong sense of belonging, improved health and wellbeing. They particularly enjoy the opportunity to 'get out of the house' and men with partners consistently talked about the need to avoid being 'underfoot' at home and to establish and develop new friendships and networks with other men.

Sheds attract people who tend not to be found in adult and community education and who are difficult to reach through community based education, health and wellbeing programmes. KCC wants to develop work with partnerships and local community development groups to provide a unique way of supporting both ex-service personnel and others at risk of social isolation and/or poor mental wellbeing. For some, this may be a stepping stone to help a Shedder into employment if this is the Shedders' ambition.

The national Shed movement has deliberately been focused primarily, but not exclusively on men and the majority of people attracted to this activity are men. Kent Sheds is however open to men and women of all ages.

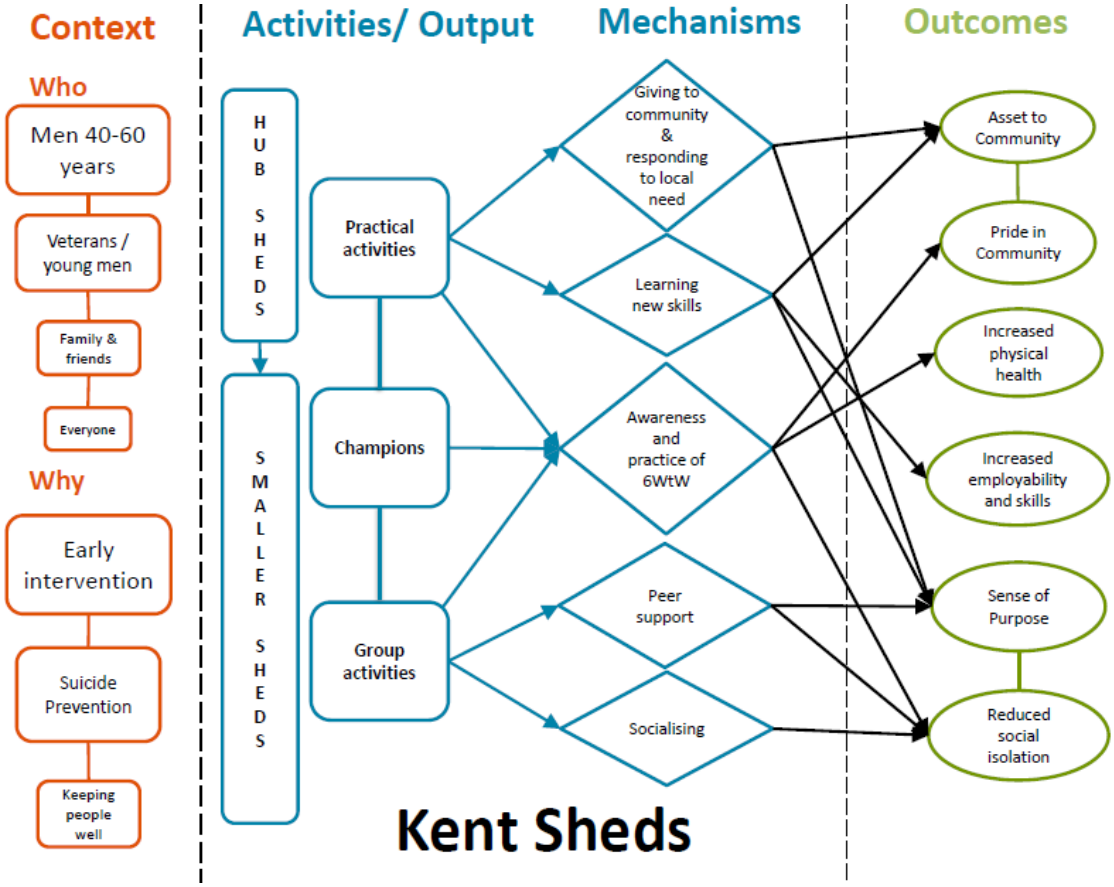
KCC procured the community insights organisation Activmobs to work within local communities to identify individuals who were interested in creating a Shed, and support them to think about what would work for them locally. Activmobs helped to shape the Kent Sheds programme and ensure it would deliver what was needed in local communities.

KCC commissioned Groundworks South to lead the development of the Sheds programme, publicising and raising awareness of the programme, and supporting new Sheds to get off the ground. There have been numerous articles in local papers and other local publicity promoting the initiative which featured in a TV documentary called "Better Shed than Dead". http://www.bettershedthandead.co.uk/. Groundworks established the Kent Sheds website, www.kentsheds.co.uk, which encourages anyone interested in starting up a Shed to be part of the Kent Sheds network, offering support and advice. It has a toolkit and details of a small development fund.

There are currently 25 Sheds across Kent, representing one of the highest densities of Sheds in the UK. There is much diversity in the Sheds funded. Many are themed around sustainable activities such as gardening, woodwork, boats or arts, whilst others are focused on supporting the local community.

Since 2013, the programme has become popular with local people, and has approximately 250 members attending Sheds on a regular basis. Kent Sheds have now seen over 5,000 attendances. Based on initial analyses of the Warwick Edinburgh Mental Wellbeing Score taken over the first 2 years of the programme, 87% of Shedders improved their wellbeing score. A number of Shedders have also gone on to gain paid employment as a result of their work in Sheds.

This initiative helps support KCC, delivering a number of key outcomes, including those set out in the Care Act, KCC's Strategic Statement and Public Health Outcomes Framework.



Users', voluntary sector and carers' views are sought as part of the gathering of data in all needs assessments. Historically there has been considerable input mentioned; for example, the carers' needs assessment and mental health users in the mental health needs assessment.

Various methods of involvement have been used, from engaging with service users via local planning meetings and invited workshops. All the key issues the service users highlighted are reflected in this strategy, notably better outcomes for people needing dual diagnosis services and better mental health treatment for offenders.

As a separate exercise, KCC commissioned Activmob as specialists in engaging and talking with communities. Activmob was asked to support Kent Public Health in ensuring feedback from engagement activities, consultations and user involvement could be incorporated and evidenced in the JSNA Overview Report.

The objectives were to:

- identify what engagement activities, consultations and user involvement there has been within each of the "chapter" areas of the JSNA
- locate 'source' information to enable the Kent Public Health team to access this data and inform their writing of the JSNA
- identify any gaps in engagement activities and user involvement

- facilitate appropriate engagement activities for identified areas and summarise public insights and feedback.

Healthwatch provided data around contacts they had had with the public regarding hospital services, social care services and community health services, which increased from 255 in 2013-14 to 1081 in 2014-15. These contacts with the public are an important aspect of patient and client information and should be developed further.

Appendix B

JSNA Products

Product	Purpose	By whom	Timescale for refresh
JSNA Overview Summary Report	Report summarising population needs by Kent, CCG and district population as well as key programme areas	Compiled by the consultant lead for JSNA and Head of Public Health Intelligence	Every three years Current Overview Summary Report (PDF, 2.3 MB)
JSNA Exception Report	Report summarising updates and exceptions in the intervening three year refresh period of JSNA overview summary report	Consultant lead for JSNA	Every December Current Exception Report (PDF, 587.7 KB)
JSNA Programme Chapter Summaries	Electronic chapters describing key issues and recommendations across 40 different programme areas and risk groups	Consultant and specialist lead for the different areas	Update to be completed every September Programme chapter summaries
Health and Social Care Maps (HSCM)	Articulate needs of population at a sub Kent level across 10 key areas and up to 70 different indicators/measures	Kent Public Health Observatory. A data subgroup of the JSNA/JHWS group will oversee its development	Varies by indicator from quarterly to yearly Health and Social Care Maps
CCG Profiles/Needs Assessments	These are done at local CCG/HWB level to articulate key priorities and gaps which build on work done at a Kent level as well.	Respective consultant leads	Depends on local HWB/CCG priorities and expectations CCG Profiles
Needs Assessment and Equity Audits	These are done across different programme areas and risk groups	Consultant and specialist leads	Depends on local priorities and expectations Needs assessments and equity audits