## 8 | Older People (65+)

**Summary :** Seasonal flu vaccination uptake was generally higher in the over 65s than in other at-risk groups and uptake was broadly the same in the East Kent CCGs. The effectiveness of the vaccine in the older ages groups was particularly low at 10.1% in 2017/18 which led to the 2018/19 vaccine being quadrivalent and a booster vaccine offered. Emergency admissions rates for falls is lower in East Kent than the Kent average. The trend has been similar for the past few years.

Social isolation is becoming an increasingly recognised issue that can affect health and wellbeing and is strongly linked with mental health issues and premature mortality. It is difficult to quantify, however using ACORN classification some wards were highlighted where there is a greater chance that more socially isolated older people reside.

Social care packages could be examined in much greater detail than the scope of this needs assessment allows, but high level analysis showed that a higher proportion of older residents in Thanet CCG were receiving some kind of social care package than the other three East Kent CCGs. West Kent CCG had the lowest rate in Kent overall.

Due to older people having higher vulnerabilities to deaths from COVID19 proactive health care and preventative measures must be taken to protect older people from infectious disease – particularly centred in supporting care homes.

## Recommendations

- Investigate further the join up between health and social care in east Kent
- Tackle Multi-morbidity together in local care systems
- Work with a range of community partners to improve access to connections and social support that keep people active and engaged as possible as they age: e.g care navigation/ social prescribing, community groups
- Prioritise local self help groups in maintaining and managing health and wellbeing.
- Ensure access to services are equitable e.g. mental health services
- Prevent frailty by training staff to have 'difficult conversations' about physical activity and social connection
- Ensure services are accessible and timely to prevent early death.

## 8.1 Infographic Summary of Older People's Health in East Kent

The infographics below provide a summary of key data relating to the health and wellbeing of older people in Ashford, Canterbury & Coastal, South Kent Coast and Thanet CCGs taken from the KPHO Health and Social Care Maps<sup>1</sup>.



<sup>&</sup>lt;sup>1</sup> <u>https://www.kpho.org.uk/health-and-social-care-maps/pdf-social-care-maps</u>







## 8.2 Income Deprivation Impacting on Older People

There is a separate index of deprivation which is used to describe deprivation in older people. The Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of all those aged 60 or over who experience income deprivation. It is a subset of the Income Deprivation Domain which measures the proportion of the population in an area experiencing deprivation relating to low income.

Collectively, a larger number of wards in all East Kent CCGs are highlighted as being amongst the 20% most deprived wards in respect of those aged 60 years and over who experience income deprivation.

Ashford CCG

- Aylesford Green
- Beaver
- Norman
- Stanhope
- Victoria

#### Canterbury & Coastal CCG

- Davington Priory
- Heron
- Northgate

#### South Kent Coast CCG

- Maxton, Elms Vale and Priory
- St Radigunds
- Aylesham
- Buckland
- Castle
- Tower Hamlets
- Town & Pier

- Folkestone East
- Folkestone Foord
- Folkestone Harbour
- Folkestone Harvey Central

#### Thanet CCG

- Westgate-on-Sea
- Garlinge
- Westbrook
- Margate Central
- Cliftonville West
- Dane Valley
- Beacon Road
- Sir Moses Montefiore
- Northwood
- Eastcliff
- Central Harbour
- Newington
- Salmestone

#### Figure 250: IMD 2015 – Income deprivation affecting older people index (IDAOPI)

#### Income Deprivation Affecting Older People Index (IDAOPI): by electoral ward

The percentage of those aged 60 or over who experience income deprivation, population weighted quintile, 2015



#### Figure 251

#### Income Deprivation Affecting Older People Index (IDAOPI): by electoral ward

The percentage of those aged 60 or over who experience income deprivation, population weighted quintile, 2015



#### Figure 252:

#### Income Deprivation Affecting Older People Index (IDAOPI): by electoral ward

The percentage of those aged 60 or over who experience income deprivation, population weighted quintile, 2015



#### Figure 253

## Income Deprivation Affecting Older People Index (IDAOPI): by electoral ward

The percentage of those aged 60 or over who experience income deprivation, population weighted quintile, 2015



## 8.3 Life Expectancy at Age 65

Life expectancy at age 65 years is 19.2 years for males and 21.6 years for females in Ashford CCG and 19.2 years for males and 21.5 years for females in Canterbury and Coastal CCG. Both CCGs were found to be similar to the Kent average at 18.9 for males and 21.3 for females.

In South Kent Coast CCG life expectancy at age 65 is 18.6 years for males and 21.1 years for females, and 18.1 years for males and 20.1 years for females in Thanet CCG. Life expectancy at age 65 in Thanet CCG is significantly lower than the Kent average for both males and females.



#### Figure 254: Life expectancy at 65 years – by CCG

Source: ONS, NHS Digital, PHE, prepared by KPHO (ZC), Nov-18



Life expectancy at 65 years, female: by CCG

Source: ONS, NHS Digital, PHE, prepared by KPHO (ZC), Nov-18

There is significant variation in ward-level life expectancy at 65 across East Kent. Kingsgate (in Thanet CCG) has the highest life expectancy for both males (24.6 years) and females (30 years). The ward with the lowest life expectancy is Cliftonville West (in Thanet CCG) for both males (14.3 years) and females (16 years).

In Ashford CCG there are no wards that have significantly lower life expectancy at 65 than the Kent average for either males or females.

Heron and Abbey wards in Canterbury and Coastal CCG and Lydden and Temple Ewell in South Kent Coast CCG have significantly lower life expectancy at 65 than the Kent average for both genders.

In Thanet CCG Salmestone, Westgate-on-sea, Beacon Road, Eastcliff, Margate Central, Cliftonville West and Newington wards all have significantly lower life expectancy at 65 than the Kent average for both males and females.

Life expectancy at age 65 is a mortality-based indicator and is thought to be influenced at small geographical levels by volumes of care home placements, with higher volumes tending to lower the life expectancy, especially if a high proportion of the population is below 65<sup>2</sup>. However, this is not the only factor in mortality, deprivation is still key driver of life expectancy.

<sup>&</sup>lt;sup>2</sup> Williams et al (2004) Impact of nursing home deaths on life expectancy calculations in small areas. J Epidemiology Community Health 58, 958-962

#### Figure 256: Life expectancy at 65 years - by ward

#### Life expectancy at 65 years, male: by electoral ward

Figures based on deaths registered and mid-year population estimates, life expectancy in years calculated using the Public Health England calculator, 2013-2017



#### Figure 257



#### Life expectancy at 65 years, male: by electoral ward

Figures based on deaths registered and mid-year population estimates, life expectancy in years calculated using the Public Health England calculator, 2013-2017



Source: ONS, NHS Digital, PHE, prepared by KPHO (ZC), Nov-18

#### Figure 259



Source: ONS, NHS Digital, PHE, prepared by KPHO (ZC), Nov-18



#### Figure 261



Figures based on deaths registered and mid-year population estimates, life expectancy in years calculated using the Public Health England calculator, 2013-2017





## 8.4 Seasonal Flu Vaccination

Influenza (flu) is a viral infection that affects the lungs and airways. There are 2 types; Influenza A and Influenza B. It occurs most often in winter in the UK and peaks between January and March and is a key factor in NHS winter pressures. The symptoms often appear very quickly and can include:

- Headache
- Fever
- Cough
- Sore throat
- Aching muscles and joints

Whilst for most it is a self-limiting condition, it can cause complications such as bacterial pneumonia and can be life-threatening especially in:

- Older people
- The very young
- Pregnant women
- Those with underlying disease, particularly chronic respiratory or cardiac disease
- Those who are immunosuppressed

The national flu immunisation programme aims to reduce the impact of flu in the population through a series of complementary measures. In this programme, those aged 65 and over, pregnant women and those in a clinical risk group are offered annual vaccination. In addition, those living in long-stay residential care home, people who are carers and all frontline health and social care workers should also be offered flu vaccination.

In 2012 it was recommended that flu vaccination was extended to healthy children aged two to seventeen. Due to the scale of implementation of this programme, it has been phased in. Currently the NHS offers the live attenuated influenza vaccination to:

- children aged 2 and 3 on August 31st 2018 that is, children born between September 1st 2014 and August 31st 2016
- children in reception class and school years 1, 2, 3, 4 and 5
- in some parts of the country, all primary school-aged children will be offered the vaccine (following a pilot in some areas)
- children aged 2 to 17 with long-term health conditions

For the 2017/18 flu season, analysis of the data showed that the flu vaccine was 15% effective across all age groups. This varied considerably by age-group with it being 26.9% effective in children aged 2 to 17 compared to 10.1% in those aged 65 and over. Due in part to the lack of effectiveness in older people, a new 'booster' vaccine was made available in the 2018/19 season. In addition, the quadrivalent vaccine was recommended which protects against 4 strains of flu, rather than the previous vaccines of 3 strains.

The provisional national seasonal flu vaccine cumulative uptake to end of February 2019<sup>3</sup>, shows that uptake in the 65 years and older group was 72.6%, the under-65's at risk group uptake was 48% and the pregnant women uptake was 47.2%. The graph below shows that the position of the East Kent CCGs to be broadly similar.

<sup>&</sup>lt;sup>3</sup> <u>https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-monthly-data-2018-to-2019</u>



There is a relatively new NICE guideline<sup>4</sup> published in August 2018 with collaboration from Public Health England, that aims to increase uptake of flu vaccination. It details both awareness on generally raising awareness of flu vaccination and specifically, in eligible groups. It gives practical suggestions of how to try to increase uptake such as the possibility of using peer-led approaches for inviting people in underserved groups who are eligible for a flu vaccination, and suggests providing flu vaccination during routine appointment in specialist clinics to people who are at high risk from flu and its complications. For example, people with immunosuppression, chronic liver or neurological disease, and pregnant women.

<sup>&</sup>lt;sup>4</sup> <u>https://www.nice.org.uk/guidance/ng103/resources/flu-vaccination-increasing-uptake-pdf-66141536272837</u>

## 8.5 Falls

The age-standardised rate of emergency hospital admissions due to falls amongst those aged 65+ is lower across all East Kent CCGs than the Kent average. Trend analysis suggests that whilst there has been no significant change in admission rates in Ashford, Canterbury & Coastal and Thanet CCGs, there is evidence of a decrease in South Kent Coast CCG.

There is variation between electoral wards, with Margate Central having a higher admission rate due to falls than the Kent average.





Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (MP), Nov-18





No significant change compared with a stable trend for Kent

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (MP), Nov-18

#### Figure 266



No significant change compared with a stable trend for Kent

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (MP), Nov-18



#### Emergency hospital admissions due to falls in people aged 65 and over: trend

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (MP), Nov-18





Emergency hospital admissions due to falls in people aged 65 and over: trend Age standardised rate per 100,000 people aged 65 and over, ICD 10: 500-T98 (primary diagnosis) and external cause code W00-W19, 2010/11 to 2017/18

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (MP), Nov-18

No significant change compared with a stable trend for Kent

Decreasing compared with a stable trend for Kent

#### Figure 269: Hospital admissions due to falls in people aged 65+ - by ward

Emergency hospital admissions due to falls in people aged 65 and over: by electoral ward

Age standardised rate per 100,000 people aged 65 and over, ICD 10: S00-T98 (primary diagnosis) and external cause code W00-W19, 2015/16-2017/18



Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (MP), Nov-18

#### Figure 270

#### Emergency hospital admissions due to falls in people aged 65 and over: by electoral ward

Age standardised rate per 100,000 people aged 65 and over, ICD 10: S00-T98 (primary diagnosis) and external cause code W00-W19, 2015/16-2017/18



#### Emergency hospital admissions due to falls in people aged 65 and over: by electoral ward

Age standardised rate per 100,000 people aged 65 and over, ICD 10: 500-T98 (primary diagnosis) and external cause code W00-W19, 2015/16-2017/18



Figure 272

#### Emergency hospital admissions due to falls in people aged 65 and over: by electoral ward



Age standardised rate per 100,000 people aged 65 and over, ICD 10: 500-T98 (primary diagnosis) and external cause code W00-W19, 2015/16-2017/18

## 8.6 Social Isolation

Research has shown that, in terms of negative health outcomes, lacking social connections is comparable to smoking 15 cigarettes a day, and has worse health outcomes than risk factors such as obesity and physical inactivity. It has been calculated that loneliness increases the likelihood of mortality by 26% in older people. Research also suggests that social frailty has a stronger impact on the onset of depressive symptoms than physical frailty or cognitive impairment.

This section provides an analysis of East Kent residents aged 65+ who have been identified as living alone and falling into one of the 11 Wellbeing Acorn types identified as having a higher than average isolation index<sup>5</sup>. The Wellbeing ACORN classifications are on based on demographic, socio-economic, population, health and consumer behaviour. The segments are designed to provide insights into people's health and wellbeing.

The maps below show wards in Ashford, Canterbury and Coastal, South Kent Coast and Thanet CCGs with high *numbers* of individuals identified. Wards falling into the highest quintile are highlighted, i.e. the 20% of Kent wards with the highest numbers of older residents identified.

<sup>&</sup>lt;sup>5</sup> <u>https://www.kpho.org.uk/\_\_data/assets/pdf\_file/0008/87362/Social-isolation-and-loneliness-in-Kent.pdf</u>

# Figure 273: Numbers of older people more likely to be experiencing social isolation/loneliness – by ward



Older people more likely to be experiencing social isolation/loneliness: by electoral ward Number identified belonging to a Wellbeing Acorn type with a high calculated 'isolation index', aged 65+ and living alone, 2018

#### Figure 274



Older people more likely to be experiencing social isolation/loneliness: by electoral ward Number identified belonging to a Wellbeing Acorn type with a high calculated 'isolation index', aged 65+ and living alone, 2018

Older people more likely to be experiencing social isolation/loneliness: by electoral ward Number identified belonging to a Wellbeing Acorn type with a high calculated 'isolation index', aged 65+ and living alone, 2018



Source: CACI, Kent Integrated Dataset (KID), prepared by KPHO (RK), Jul-18



Older people more likely to be experiencing social isolation/loneliness: by electoral ward Number identified belonging to a Wellbeing Acorn type with a high calculated 'isolation index', aged 65+ and living alone, 2018

The maps below show wards in Ashford, Canterbury and Coastal, South Kent Coast and Thanet CCG with high *percentages* of their populations identified as being older people more likely to be experiencing social isolation or loneliness. Results are shown based both on the percentage of the total population identified as being at risk, and on the percentage of the population aged 65+. In each case wards falling into the highest quintile are highlighted, i.e. the 20% of Wards with the highest percentages of residents identified.

Source: CACI, Kent Integrated Dataset (KID), prepared by KPHO (RK), Jul-18

## Figure 277: Percentage of the total population identified as being more likely to be experiencing social isolation/loneliness - by ward

% of the population who are older people more likely to be experiencing social isolation/loneliness: by electoral ward



Source: CACI/Kent Integrated Dataset (KID), ONS, prepared by KPHO (RK), Jun-18

#### Figure 278

% of the population who are older people more likely to be experiencing social isolation/loneliness: by electoral ward



Source: CACI/Kent Integrated Dataset (KID), ONS, prepared by KPHO (RK), Jun-18

% of the population who are older people more likely to be experiencing social isolation/loneliness: by electoral ward Percentage of population aged 65+ identified as belonging to a Wellbeing Acorn type with a high calculated 'isolation index', aged 65+ and living alone, 2018



Source: CACI/Kent Integrated Dataset (KID), ONS, prepared by KPHO (RK), Jun-18

Figure 280

#### % of the population who are older people more likely to be experiencing social isolation/loneliness: by electoral ward



Percentage of population aged 65+ identified as belonging to a Wellbeing Acorn type with a high calculated 'isolation index', aged 65+ and living alone, 2018

## Figure 281: Percentage of the population aged 65+ identified as being more likely to be experiencing social isolation/loneliness – by ward



% of older people more likely to be experiencing social isolation/loneliness: by electoral ward

Source: CACI/Kent Integrated Dataset (KID), ONS, prepared by KPHO (RK), Jun-18



% of older people more likely to be experiencing social isolation/loneliness: by electoral ward Percentage of population aged 65+ identified as belonging to a Wellbeing Acorn type with a high calculated 'isolation index', aged 65+ and living alone, 2018

Source: CACI/Kent Integrated Dataset (KID), ONS, prepared by KPHO (RK), Jun-18

#### Figure 283



% of older people more likely to be experiencing social isolation/loneliness: by electoral ward Percentage of population aged 65+ identified as belonging to a Wellbeing Acorn type with a high calculated 'isolation index', aged 65+ and living alone, 2018

#### % of older people more likely to be experiencing social isolation/loneliness: by electoral ward



Percentage of population aged 65+ identified as belonging to a Wellbeing Acorn type with a high calculated 'isolation index', aged 65+ and living alone, 2018

## 8.7 Social Care

Social care is a fundamental part of an integrated care system. Adult social care describes the activities, services and relationships that help people live independent, healthy, active and inclusive lives. It covers a great variety of services, delivered by many different providers, in a selection of settings. For example, adult social care can include domiciliary (home) care, residential care, nursing care, day care opportunities, short respite breaks and the provision of equipment. Local authorities apply national criteria to assess whether people are eligible for social care.

The chart below shows the rate of the over 65 population in receipt of social care support from Kent County Council Adult Social Care services in 2017-18. Ashford CCG has a below average age-standardised rate of usage compared to the Kent average (6,740 per 100,000). Three of the four East Kent CCGs (Ashford, Canterbury & Coastal and South Kent Coast) have lower age-standardised rates of usage compared to the 2 North Kent CCGs (Dartford, Gravesham & Swanley and Swale). Overall, West Kent has the lowest usage.

#### Figure 285



## **Conclusion:**

Older people in East Kent are dying earlier then people then people in Kent on average. They are dying earlier in places of highest deprivation. They are dying – by and large- from preventable diseases, e.g Lung Cancer and COPD. Around 50% of people will have 2+ long term health conditions aged 65+. People are more socially isolated in rural and deprived areas. People who lead stressful and inactive lives tend to get frailer earlier. East Kent appears to have made inroads into preventing falls. Social care packages appear to be less in East Kent then Kent overall

The elderly population is set to considerably increase across East Kent in the foreseeable future. Income deprivation affecting older people is a domain of the IMD that shows relative poverty, Thanet CCG, and to a lesser degree South Kent Coast CCG, have high proportions of their wards in the most deprived quintile of IDAOPI for Kent.

Life expectancy at age 65 has been shown to be significantly lower in Thanet CCG than Kent. When examined at ward level, there is a difference of over 10 years life expectancy between the highest and lowest wards. Although some of the extreme figures can be skewed by high proportions of care homes in the area, there is still a strong correlation with deprivation.

Seasonal flu vaccination uptake was generally higher in the over 65's than in other at-risk groups and uptake was broadly the same in the East Kent CCGs. The effectiveness of the vaccine in the older ages groups was particularly low at 10.1% in 2017/18 which led to the 2018/19 vaccine being quadrivalent and a booster vaccine offered.

Emergency admissions rates for falls is lower in East Kent than the Kent average. The trend has been similar for the past few years.

Social isolation is becoming an increasingly recognised issue that can affect health and wellbeing and is strongly linked with mental health issues and premature mortality. It is difficult to quantify, however using ACORN classification some wards were highlighted where there is a greater chance that more socially isolated older people reside.

Social care could be examined in much greater detail than the scope of this needs assessment allows, but high level analysis showed that a higher proportion of older residents in Thanet CCG were receiving some kind of social care package than the other 3 East Kent CCGs. West Kent CCG had the lowest rate in Kent overall.

#### **Recommendations:**

- Investigate further the join up between health and social care in east Kent.
- Tackle Multi-morbidity together in local care systems.
- Work with a range of community partners to improve access to connections and social support that keep people active and engaged as possible as they age: e.g. care navigation/ social prescribing, community groups.
- Prioritise local self help groups in maintaining and managing health and wellbeing.
- Ensure access to services are equitable e.g mental health services
- Prevent frailty by training staff to have 'difficult conversations' about physical activity and social connection.
- Ensure services are accessible and timely to prevent early death.

## 9 | Lifestyle Factors Affecting Health and Healthy Aging

## 9.1 Alcohol

Alcohol misuse leads to a range of public health problems and acute conditions, such as alcohol poisoning, violence and accidents which can be attributed to alcohol. There are a number of alcohol related chronic conditions such as alcohol-induced pancreatitis, chronic liver disease and digestive tract cancers which all lead to reduced health and wellbeing and at worst, loss of life. Alcohol misuse contributes to stroke and hypertension, as well as mortality related to liver disease.

Consequently the public health effects of high alcohol consumption can be seen across the whole society. This ranges from the need to access hospital care to social effects such as the economic burden due to loss of employment and reduced capacity to work. Further negative effects of alcohol are seen both at individual and community level, for example, behavioural changes resulting in acts of violence, anti-social behaviour, accidents or crime, risky sexual activity leading to teenage conceptions and sexually transmitted infections, and poor educational attainment.

Alcohol and Drug misuse services in West Kent have been re- commissioned and since April 2016 services are provided by CGL (<u>https://www.changegrowlive.org/</u>) with an increased focus on case-working and wrap around support, utilising the skills and assets within the Health and Wellbeing Team and the Programmes/Groupwork Team as well brokering support from partner and community based agencies and the West Kent Volunteers and Recovery Champions to develop comprehensive recovery support plans for all service users.

A recent PHE review entitled 'Alcohol and Drug prevention, why invest?' estimates that the cost of alcohol misuse to society is around £21 billion and drugs £11 billion. It was also estimated that there is a £3 social return for every £1 spent on alcohol treatment, and £4 return for drug treatment<sup>6</sup>.

## 9.1.1 Consumption

It is estimated that nationally 21% of the adult population are drinking above the recommended maximum levels of 14 units of alcohol a week<sup>7</sup>. This equates to approximately 145,000 across the four East Kent CCGs. Drinking at above the recommended levels has been declining steadily, from a reported 26% of the population in 2011. Nationally, drinking at higher and hazardous levels above 35 units per week however has remained steady at around 6 to 7% of the population, equating to around 40,000 people in East Kent.

<sup>&</sup>lt;sup>6</sup> <u>https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest</u>

<sup>&</sup>lt;sup>7</sup> Calculated based on Health Survey for England data on adults drinking over 14 units of alcohol a week (2017), applied to the mid-2017 18+ resident population for DGS and Swale CCG.

Public Health England have found a correlation between alcohol off-trade sales and alcoholspecific hospital admissions, which is available at local authority level as shown below in litres of pure alcohol per adult per year. No such association was found for on-trade sales (in pubs and restaurants), which account for approximately 50% of sales.



#### Figure 286: Volume of alcohol sold through the off-trade

Source - PHE, prepared by KPHO (MP) Jan 2019

## 9.1.2 Economic Costs of Alcohol Consumption

The Governments Alcohol Strategy (2012) estimated that the total cost to society in England at £21 billion per year; £3.5 billion to the NHS, alcohol related crime was estimated at £11 billion and lost productivity at £7.3 billion (2010/11 costs). Other estimates have costs ranging between from £20 billion to £55 billion in England inclusive of a variety of non-medical costs (ibid).

Alcohol misuse has implications for the health and behaviour of employees with lost productivity - estimated to be about £7.3 billion per year by the Commons health select committee in 2012<sup>8</sup>.

Of the costs to the National Health Service (NHS) the four largest disease conditions associated with alcohol harms are:

- heart disease
- stroke
- liver disease
- cancer

<sup>&</sup>lt;sup>8</sup> https://publications.parliament.uk/pa/cm201213/cmselect/cmhealth/132/132we01.htm

Accident and Emergency attendances (about 70% are related to alcohol at weekends) and hospital admissions, have more than doubled over the last 15 years to approximately a million episodes<sup>9</sup>.

In Kent, a report by Alcohol Concern in 2015 estimated the costs to the NHS alone have been £71.2 million, or £59 per adult. This is estimated to be £47.4m for inpatient admissions, £16.6m cost of A&E visits and 7.1m in outpatients. £21.9m of this cost is in the 55 to 74 age group, compared to £12.9m in 25-54 year old, and over two thirds of the cost of admissions in males.

## **Emergency Departments**

The commons health select committee found that in 2009/10 that there were more than 7.1 million alcohol – related emergency department (ED) attendances which cost the NHS £696 million. Estimates for alcohol-attributable ED admissions range from 2% to 40% rising to 70% at peak times. Research suggests that the proportion of total consultant time dedicated to intoxicated patients is around 25%.

#### **Prescribing costs**

The total Net Ingredient Cost (NIC) for items prescribed for alcohol dependence in 2015 was £3.93 million. This is 15% higher than in 2014 when the total NIC was £3.42 million and more than double the level ten years ago (NHS Business Services Authority, 2015). No data is available for Kent.

## 9.1.3 Hospital Admissions

The rate of admissions to hospital for alcohol-specific conditions in Canterbury & Coastal and Thanet CCGs are above the Kent average, South Kent Coast CCG is the same as the Kent average and Ashford CCG is below average. There is, however, considerable variation between electoral wards. The hospital admission rate due to alcohol-specific conditions is higher than the Kent average in:

<sup>&</sup>lt;sup>9</sup> Public Health England, 2014

Ashford CCG:

- Beaver
- Stanhope
- Downs West

### Canterbury & Coastal CCG

- Heron
- Northgate
- Sturry North
- Harbour
- Wincheap
- Davington Priory
- Marshside
- Westgate

#### South Kent Coast CCG

- Folkestone Harbour
- Castle
- Folkestone Harvey Central
- Folkestone East
- Folkestone Harvey West
- Town & Pier
- St Radigunds
- Middle Deal & Sholden

#### Thanet CCG

- Cliftonville West
- Margate Central
- Eastcliffe
- Central Harbour
- Westbrook
- Newington

#### Figure 287: Hospital admissions for alcohol-specific conditions – by CCG



#### Hospital admissions for alcohol-specific conditions: by CCG

Age standardised rate per 100,000 population, ICD10: E244, F10, G312, G621, G721, I426, K292, K70, K852, K860, Q860, R780, T510, T511, T519, X45, X65, Y15, Y90, Y91, 2013/14-2017/18

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Jan-19
#### Figure 288: Hospital admissions for alcohol-specific conditions - trend



No significant change compared with a stable trend for Kent

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Jan-19





No significant change compared with a stable trend for Kent

# Figure 290



Decreasing compared with a stable trend for Kent

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Jan-19

#### Figure 291



No significant change compared with a stable trend for Kent

#### Figure 292: Hospital admissions for alcohol-specific conditions – by deprivation



Hospital admissions for alcohol-specific conditions: by deprivation Age standardised rate per 100,000 population, ICD10: E244, F10, G312, G621, G721, I426, K292, K70, K852, K860, Q860, R780, T510, T511, T519, X45, X65, Y15, Y90, Y91, 2010/11 - 2014/15 to 2013/14 - 2017/18

Least deprived trend - increasing compared with stable trend for Kent

Most deprived trend - no significant change compared with decreasing trend for Kent

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Jan-19





Least deprived trend - decreasing compared with stable trend for Kent Most deprived trend - no significant change compared with decreasing trend for Kent

#### Figure 294



Hospital admissions for alcohol-specific conditions: by deprivation

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Jan-19





Least deprived trend - no significant change compared with stable trend for Kent Most deprived trend - decreasing with a faster pace of change than Kent

Least deprived trend - no significant change compared with stable trend for Kent Most deprived trend - decreasing with a similar pace of change to Kent

#### Figure 296: Hospital admissions for alcohol-specific conditions - by ward



#### Figure 297



#### Hospital admissions for alcohol-specific conditions: by electoral ward

Age standardised rate per 100,000 population, ICD10: E244, F10, G312, G621, G721, I426, K292, K70, K852, K860, Q860, R780, T510, T511, T519, X45, X65, Y15, Y90, Y91, 2013/14-2017/18

#### Figure 298



Hospital admissions for alcohol-specific conditions: by electoral ward

#### Figure 299



## 9.1.4 Liver Disease

Liver disease is a leading cause of premature mortality nationally. Alcohol and obesity are contributing factors and a large proportion of liver disease is considered 'preventable' meaning that deaths could be prevented through public health interventions or lifestyle modification.

Thanet has significantly higher rates of premature mortality both from liver disease and preventable liver disease than Kent as a whole.

The rate of under 75 mortality from alcoholic liver disease in Kent (only available at county level) is approximately half the rate of all preventable liver disease. This gives some indication of the proportion of deaths from preventable liver disease that are alcohol related.

# Figure 300: Premature mortality from liver disease and from alcoholic liver disease: by district



Source: PHE, prepared by KPHO (SR), July 2019

Figure 301 below shows the proportion of deaths from liver disease that are considered preventable by district. Folkestone and Hythe district has a higher proportion of deaths that are considered preventable (92.9%) than the other East Kent districts and it is also higher than both the Kent and England averages.



#### Figure 301: Premature mortality from liver disease: by district

Mortality from liver disease: proportion of deaths considered preventable by public health intervention, 2015-17

Source: PHE Fingertips, prepared by KPHO (SR), July 2019

## 9.1.5 Crime and Alcohol

Alcohol has been shown to have a strong link to violent crime and domestic abuse and can lead to both immediate healthcare costs of wounds and injuries, and long-term costs affecting mental health. It is estimated 40% of violent crimes and 30% of domestic violent incidents are committed where the perpetrator is under the influence of alcohol<sup>10</sup> as perceived by the victims. Of all violent crime, 47% resulted in an injury, 15% needed medical attention and 1% needed admitted patient care.

The East Kent local authorities of Dover, Folkestone & Hythe, Swale and Thanet experienced more violent injuries per head of population than the Kent and England averages in 2016/17.

<sup>10</sup> 

https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/natureofcrimetablesviolence



#### Figure 302: Violent offences per 1,000 population

**Road traffic accidents** are another significant source of secondary care usage. Kent has been shown to be significantly higher that England for road traffic accidents where a breath test was failed by at least one driver, as shown below.



Figure 303: Alcohol related road traffic accidents

# 9.1.6 Mortality from Alcohol

It has been shown that approximately 3% of all deaths are alcohol related. Of this 3 per cent, alcohol-specific deaths e.g. alcohol poisoning, alcoholic liver disease or acute pancreatitis account for about one third are *directly caused* by alcohol misuse. The other two thirds *are related* to alcohol misuse e.g. stroke, heart rhythm disorders, throat cancers as well as falls, accidents or violence.

In East Kent, Thanet and Folkestone & Hythe local authorities show significantly higher rates of alcohol specific mortality than the Kent and England averages, and Thanet shows significantly higher alcohol-related mortality. Trends over time have been steady across all districts in East Kent.

Thanet and Folkestone & Hythe local authorities also show significantly higher rates of mortality from liver disease than the Kent and England averages.



Figure 304: Alcohol-specific mortality

Source - PHE, prepared by KPHO (MP) Jan 2019

#### Figure 305: Alcohol-related mortality



Source - PHE, prepared by KPHO (MP) Jan 2019





Source - PHE, prepared by KPHO (MP) Jan 2019

# 9.2 Substance Misuse and Other Illicit Drugs

Recreational illicit drug use is pervasive in modern society with around 10% of adults reporting drug use within the past year, but evidence suggests recreational drug use is on a declining trend. Regular drug use and use of harder class A drugs, however, remains problematic, and in general is not declining. There are strong links between the prevalence of problem drug use and levels of deprivation, drug related hospital admissions and

mortality<sup>11</sup>. Typically, individuals using drugs are often involved in drug dealing and acquisitive crime and suffer a range of adverse effects to their health and wellbeing, including infection with blood borne viruses (hepatitis B and C and HIV), depression, unemployment, homelessness and custodial sentences. There are also well-recognised and serious consequences for the children of problem drug users, including the risk of abuse or neglect and the disruption of family life.

# 9.2.1 Prevalence of Drug Use

The Crime Survey for England and Wales<sup>12</sup> reports that there has been a long-term decline in the overall self-reported use of drugs within the last year in the 16-59 age groups, although the 2017/18 data suggested a small increase since 2016/17. Those aged 16-24 years are more likely to use drugs and recent years have shown an increase of self-reported use amongst 20-24 year olds. The trend in declining drug use has not been seen in older adults who have maintained their drug use into older age. Overall, self-reported frequency of drug use has fallen slightly since 2015/16 but not significantly so.



#### Figure 307: Reported Drug use by Age Band

Self-reported Class A use within the previous year has remained largely static across 16-59year olds. An overall decline in use amongst 16-24-year olds has been observed, albeit with recent increases in the 20-24 year old group. A gradual increase has been seen in class A use amongst 30-34 and 35-44-year olds.

<sup>&</sup>lt;sup>11</sup> Shaw C, Hurst A, McVeigh J, Prof. Bellis M A. Eds. 2009 *Indications of Public Health in the English Regions 10: Drug Use.* Liverpool: North West Public Health Observatory

<sup>&</sup>lt;sup>12</sup> <u>https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2017-to-2018-csew</u>



Figure 308: Proportion of 16 to 59-year olds reporting Class A use in the last year

Overall self-reported lifetime drug use has increased since modern comparable records began in 1996. Self-reported lifetime use in 16-59s has increased overall since 1996, declined since 2007 and remained at similar levels for the past three years. Class A lifetime use has increased across all three comparative time periods, 1996, 2007 and 2016/17 to 2017/18. Modelled estimates for drug use in East Kent based on this nationally reported data are shown below.

Proportion of 16 to 59 year olds reporting use of drugs ever in their lifetime	1996	2006/07	2015/16	2016/17	2017/18	1996 to 2017/18	2007/08 to 2017/18	2016/17 to 2017/18	East Kent & Swale estimated 2017/18
			Cla	ss A					
Any cocaine	3.15	7.80	9.75	9.66	10.68	1	1	1	42,440
Powder cocaine	3.00	7.66	9.65	9.59	10.60	<b>^</b>	1	4	42,152
Crack cocaine	0.72	0.97	1.00	0.86	0.81	1		Ŷ	3,775
Ecstasy	3.83	7.42	9.39	8.95	10.05	1	<b>F</b>	1	39,339
Hallucinogens	7.78	9.21	8.51	8.22	9.10	<b>^</b>	Ŷ	1	36,123
LSD	5.44	5.47	4.42	4.61	5.21			1	20,241
Magic mushrooms	5.31	7.24	7.07	6.74	7.32	1		ł	29,602
Opiates	0.73	0.82	0.81	0.71	0.89		Ŷ		3,122
Heroin	0.62	0.72	0.58	0.55	0.64	1		Ŷ	2,396
Methadone	0.30	0.37	0.44	0.38	0.44	Þ			1,654
			Clas	s A/B					
Any amphetamine	n/a	n/a	10.33	9.22	9.92	n/a	n/a	1	40,495
Amphetamines	9.31	12.08	10.12	9.12	9.75	Ŷ	\$	₯	40,062
Methamphetamine	n/a	n/a	0.69	0.57	0.63	n/a	n/a		2,510
			Cla	ss B					
Cannabis	23.26	30.39	29.42	29.59	30.02	1	->	->	130,002
Ketamine	n/a	1.30	2.37	2.32	2.78	n/a	1	1	10,195
Mephedrone	n/a	n/a	2.01	1.84	1.86	n/a	n/a	Þ	8,100
			Clas	s B/C					
Tranquillisers	3.10	2.97	3.00	2.93	3.01	->>	-	->>	12,888
		-	Cla	ss C					
Anabolic steroids	1.08	0.63	0.83	1.08	0.94		1	>	4,756
			Ot	her					
New psychoactive substances			2.72	2.37	2.50	n/a	n/a	>	10,397
Amyl nitrite	6.55	9.20	8.30	n/a	n/a	n/a	n/a	n/a	
Glues	2.3	2.43	n/a	n/a	n/a	n/a	n/a	n/a	
		Self-re	eported dr	ug use in li	fetime				
Any Class A drug	9.62	13.99	15.39	14.99	16.07	1	1	1	65,877
Any drug	30.36	35.69	34.95	34.21	34.57	1	₽ ₽	-₹>	150,281

#### Table 15: Proportion of 16-59 year old reporting drug use in lifetime

## Table 16: Modelled estimates of 16-59 year olds reporting drug use in lifetime by district

Modelled lifetime drug usage by district, 2017/18	Kent population 16-59, 2017	Any drug	Any Class A drug	Cannabis	
Ashford	69,856	24,146	11,225	20,971	
Canterbury	96,285	33,281	15,472	28,905	
Dover	61,046	21,101	9,810	18,326	
Folkestone and Hythe	58,414	20,191	9,387	17,536	
Swale	80,850	27,946	12,992	24,271	
Thanet	72,896	25,197	11,714	21,883	
East Kent & Swale	439,347	151,862	70,600	131,892	

There is a strong relationship between deprivation and drug and alcohol misuse. Although Kent is one of the less deprived counties in England, it has areas of significant deprivation. The Crime Survey for England and Wales measures self-reported drug use by the employment domain of the wider Index of Multiple Deprivation. Typically, those in the most deprived and least deprived quintiles report higher drug and Class A use. Those in the most and least prosperous ACORN categories also show higher drug use.

Table 17: Self-reported drug use in last year by employment deprivation and Acord	n
category, 2017/18	

English Indices of	% 16-59s reporting any	% 16-59s reporting class
Deprivation (Employment)	drug use in last	A drug use in
	year	last year
20% most deprived output areas	9.9	3.6
60% middle output areas	8.7	3.3
20% least deprived output areas	9.0	4.1
ACORN category		
Affluent achievers	7.3	3.0
Rising prosperity	12.6	5.7
Comfortable Communities	7.1	2.6
Financially stretched	9.2	3.5
Urban adversity	11.2	3.8

Crack and opiate use present particular problems for users, families and society as a whole, and is strongly associated with a variety of crime, social issues and physical and mental health problems. Liverpool John Moores university<sup>13</sup> publishes estimates of opiate and crack use (OCU) at local authority level. Kent has shown a small increase in estimated OCU use between 2011/12 and 2016/17, but due to low numbers confidence ranges are wide and consequently this is not shown to be statistically significant.

<sup>&</sup>lt;sup>13</sup> <u>https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations</u>

Local prevalence estimates of Opiate and/or Crack Users (OCU)	OCU	Lower bound 95% Cl	Upper bound 95% Cl	Rate per 1,000
Kent 2016/17	5,647	2,993	8,493	5.9
Kent 2014/15	5,198	3,163	7,156	5.5
Kent 2011/12	5,028	4,558	5,851	5.4
South East 16/17	35,135	31,476	39,983	6.2
England 16/17	313,971	309,242	327,196	8.9
Local prevalence estimates of Opiates	Opiate users	Lower bound 95% Cl	Upper bound 95% Cl	Rate per 1,000
Kent 2016/17	4,642	2,899	6,432	4.9
Kent 2014/15	4,401	2,759	6,086	4.7
Kent 2011/12	4,101	2,622	5,660	4.4
South East 16/17	29,176	26,655	32,545	5.1
England 16/17	261,294	259,018	271,403	7.4
Local prevalence estimates of Crack	Crack users	Lower bound 95% Cl	Upper bound 95% Cl	Rate per 1,000
Kent 2016/17	3,580	2,103	5,377	3.7
Kent 2014/15	3,398	2,780	4,206	3.6
Kent 2011/12	2,422	967	4,041	2.6
South East 16/17	21,891	19,987	24,464	3.8
England 16/17	180,748	176,583	188,066	5.1

Table 18: Estimates of prevalence for opiate and crack use (OCU)

# 9.2.2 Drug Misuse , Economic Impact and Crime

The economic impact of substance misuse is difficult to estimate due to the range of impacts and illicit nature of drugs. The cost to society from drug misuse is estimated to be in the region of £10 - £15 billion annually, the majority of which is crime related<sup>1415</sup>. Expenditure on NHS services and drug treatment services are estimated to be circa £500m.

A governmental report on the human and financial cost of drug addiction cites a falling rate of drug related crime<sup>16</sup>. The recorded activity associated with drug offences in Kent is shown below.





Source: Kent Police

<sup>&</sup>lt;sup>14</sup> <u>https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest</u> <u>15</u>

https://webarchive.nationalarchives.gov.uk/20140727020135/http://www.nta.nhs.uk/uploads/whyinvest2fin al.pdf

<sup>&</sup>lt;sup>16</sup> <u>http://researchbriefings.files.parliament.uk/documents/CDP-2017-0230/CDP-2017-0230.pdf</u>

#### Table 19: Kent Police Recorded Offences 2015-2017

Offence	2015	2016	2017
POSSESS A CONTROLLED DRUG OF CLASS B - CANNABIS / CANNABIS RESIN	1,349	1,288	1,241
POSSESS A CONTROLLED DRUG - COCAINE	223	217	211
POSSESS WITH INTENT TO SUPPLY A CONTROLLED DRUG OF CLASS B - CANNABIS	96	145	113
POSSESS WITH INTENT TO SUPPLY A CONTROLLED DRUG OF CLASS A - HEROIN	57	83	78
CONCERNED IN PRODUCTION OF A CONTROLLED DRUG OF CLASS B - CANNABIS	97	66	72
PRODUCE CONTROLLED DRUG OF CLASS B - CANNABIS	65	66	62
POSSESS A CLASS A CONTROLLED DRUG - HEROIN	71	81	54
POSSESS A CONTROLLED DRUG OF CLASS B - AMPHETAMINE		10	52
POSSESS A CLASS A DRUG WITH INTENT TO SUPPLY - OTHER	16	23	40
POSSESS CLASS A DRUG - CRACK COCAINE	16	38	36
POSSESS WITH INTENT TO SUPPLY A CONTROLLED DRUG OF CLASS A - COCAINE			32
IMPORT A CLASS C DRUG WITH INTENT TO EVADE A PROHIBITION / RESTRICTION		S	29
POSSESS COCAINE WITH INTENT TO SUPPLY	46	70	28
POSSESS AN UNSPECIFIED CLASS A DRUG - OTHER	11	17	26
POSSESS CRACK COCAINE WITH INTENT TO SUPPLY	20	14	26
POSSESS CONTROLLED DRUG WITH INTENT TO SUPPLY OF CLASS B - CANNABIS RESIN	13	10	20
OTHER DRUG OFFENCES	381	194	215
TOTAL	2,461	2,322	2,335

Source: Kent Police 2018

# 9.2.3 Drug and Alcohol (Substance Misuse) Treatment Services in East Kent

Drug and alcohol treatment services are commissioned by Kent County Council, and funded within the Public Health budget. Success rates vary depending on the nature of the addiction. The current provider of services in East Kent is Forward Trust. The majority of those in treatment are there primarily for opioid use, and opioid treatments typically have low success rates at around 6-7%, and typically spend far longer in treatment than for other substances. Thanet district has the highest proportion of the population in treatment services as of 2016/17. It is important to note that KCC commissioned services can not be effective without co-operation from NHS, social care and Primary care and community services.



Figure 310: Adults in Kent treatment services, 2016/17

The demography of those in treatment in Kent reflect the England cohort in Kent's treatment services, with the majority of clients, over two thirds, between the ages of 30-49. Approximately 70% of clients are male.

	Kent n	Proportion of all clients	Proportion by gender		National n	Proportion of all clients %	Proportion by gender	
		%	М	F			м	F
18-29	681	22%	22%	23%	36,978	19%	17%	22%
30-39	1,126	37%	36%	39%	74,720	37%	37%	39%
40-49	888	29%	30%	27%	61,835	31%	32%	27%
50-59	329	11%	11%	10%	21,766	11%	11%	10%
60-69	58	2%	2%	1%	3,631	2%	2%	2%
70-79	1	0%	0%	0%	346	0%	0%	0%
80+	0	0%	0%	0%	63	0%	0%	0%

Table 20: Kent drug treatment services

Source: PHE, 2017

## 9.2.4 Hospital Admissions

Admissions for substance misuse have fallen across Kent for the past two years, which is in line with national trends. The East Kent CCGs have all seen significant reductions in 2017/18, although Thanet still remains the highest CCG.





Admissions in the 15 to 24 year age group have shown a more modest decline than the all age group. South Kent Coast CCG remains the CCG with the highest rate of admissions in this age group.





# 9.2.5 Mortality from Drug Misuse (Drug Deaths)

The ONS reports<sup>17</sup> that there were 3,756 deaths nationally in 2017 due to drug poisonings – the highest since records began. This includes poisonings from both legal medicinal drugs (accidents and suicides) as well as deaths from all illicit drug misuse, which has actually seen a fall (from 2,593 to 2,503) for the first time since 2012. The most significant, and continuing, rise is in cocaine deaths, up 16% to 432, a near fourfold increase since 2011.

Although deaths from heroin and/or morphine have fallen a little, over half (53%) of all deaths related to drug poisoning still involve an opiate. This is likely due to an older generation of long-term heroin users with failing health and higher overdose risks.

Nationally, 40-49 year-olds have the highest rate of drug misuse deaths but rates have slightly fallen in all age groups except the very oldest (50-69 and 70+), perhaps further supporting the idea of an ageing cohort at greatest risk of overdose death.



Figure 313: Deaths from drug misuse by age, England & Wales

New psychoactive substances (NPSs) or New Unclassified Drugs (NUDs) were banned under the Psychoactive Substances Act 2016. Since then, deaths from poisoning due to NUD use has fallen dramatically.

<sup>&</sup>lt;sup>17</sup> drug-related deaths in England and Wales



## Figure 314: Deaths from drug misuse for NUDs, England & Wales

In Kent there is a similar increase in mortality to the England and Wales, although mortality has not increased in the most recent time period, 2015-2017. Thanet, Canterbury and Folkestone & Hythe districts appear to have increased in 2015-17 compared to 2009-11 and 2012-14, although low numbers make the trends not statistically significant. The same three district are significantly higher than Kent in the 2015-2017 time period.

Figure 315: Drug Related Deaths in Kent from 2006 to 2017





## Figure 316: Deaths from drug poisoning, East Kent districts

## **Conclusions for Drug and Alcohol Misuse**

Drug use has a series of adverse and preventable effects on both individuals and society as a whole. Due to lack of recorded data, drug use is difficult to measure at smaller geographies than sub-national or sub-county, but hospital admissions, crime figures and numbers in drug treatment services can be an indication of local issues.

The patterns of drug and alcohol use is changing: There are more drug related deaths, increased use of novel psychoactive drugs, prescription drugs and steroids.

There are approximately **120,000** dependent drinkers and **5,000** Opiate & Crack addicts in east Kent and people who drink to harmful levels and take heroin and crack who live in deprived communities are most affected physically and mentally. In addition, the East Kent Substance misuse services currently have around **2000 people** who are alcohol dependent in structured treatment. East Kent services structured treatment is provided by Forward Trust and consists of assessment, medical and community detox, rehabilitation and recovery, family support. The average treatment journey is 3-6 months. Although hospital admissions due to alcohol have decreased in Kent in the last 7 years, 500 people who have more than one hospital admission for alcohol dependence. The recovery rates for Kent services are higher than the national average. However nationally and in Kent there has been a drop in the rates of severe alcohol dependent people in treatment and a national cut to in patient detox. Access to mental health services post detox across Kent is patchy and inconsistent for this client group who have high rates of suicide and self-harm. Deaths from drug use have roughly doubled in Kent between 2008-10 and 2014-16 before a slight decline in 2015-17. In particular Canterbury, Folkestone & Hythe and Thanet districts have seen increases in drug deaths in recent years. Nationally, mortality rates have been decreasing in the younger age group but not in older ages, the rate for heroin and crack in east Kent is six per 1000.

**Recommendations:** 

- Identify and Brief advice at primary care and other opportunistic front line locations equip staff to be proactive. MECC
- Identify the most vulnerable dependent drinkers and wrap wholistic local care around these patients including substance misuse services and mental health services via MDT approach.
- One You public health services to be more proactive for treating substance misuse behaviour
- Use Trauma informed approaches for treating addictions NOT only motivation based approaches
- Shared care for medication and detox and support should be routine
- Mental health services not to place artificial barriers in place post detox if the patient is assessed to have high needs for therapy.
- Develop proactive Alcohol Support Teams working across secondary and primary care via MDT models.
- Commissioning and provision between public health, police and NHS (including NHSE) to be aligned and co-operative.
- Ensure that there is enough provision for the vulnerable cohort of east Kent people who need inpatient community detox
- Ensure that there is good onward referral to Substance Misuse Services from Hospital Care

# 9.3 Smoking

Smoking is a major cause of a range of healthcare issues, most notably lung cancer, cardiovascular disease, hypertension and chronic obstructive pulmonary disease (COPD). A recent tobacco dependence needs assessment for Kent estimated there were 7,346 deaths attributable to smoking in the period of 2015-17 and an estimated 11,599 smoking attributable hospital admissions in 2017/18<sup>18,19</sup>. In addition, tobacco is a significant driver of health inequalities where it accounts for approximately half of the difference in life expectancy seen between the richest and poorest groups in society. Lower socioeconomic groups are typically more dependent, smoke more each day and find it harder to successfully quit.

## 9.3.1 Prevalence

Smoking prevalence has decreased significantly since 2012. The latest figures from the Annual Population Survey suggest that smoking prevalence in Kent was 15.0% (with a 95%

<sup>&</sup>lt;sup>18</sup> <u>https://fingertips.phe.org.uk/profile/tobacco-control</u>

<sup>&</sup>lt;sup>19</sup> <u>https://www.kpho.org.uk/\_\_data/assets/pdf\_file/0018/90702/Tobacco-Dependency-Needs-Assessment.pdf</u>

confidence range of 13.1% to 16.9%) in 2018 compared with 21% in 2012, equating to an estimated 183,000 smokers, of which 100,000 reside in East Kent.

Those in routine and manual occupations are nearly 3.5 times more likely to smoke than their counterparts in other occupations, and the APS estimates smoking prevalence in this group now stands at 28.7% in Kent, a similar rate to England.

The government has set out a long-term ambition to create a 'smoke-free generation' and has outlined several key targets for 2022. These include a reduction in overall smoking prevalence in adults to 12% or less, a reduction in smoking in pregnancy rates to 6% or less and reducing the inequality gap in smoking prevalence.

Current prevalence projections suggest Kent is on course to achieve the overall target of 12% by 2022. These projections equate to a prevalence reduction of 0.89% per year and an estimated total of 58,500 additional quits by 2022 in Kent (average of 11,700 per year). That said, if Kent is to achieve the target of reducing health inequalities, rates of decline will need to be accelerated in certain districts (particularly Ashford, Dover, Gravesham, Maidstone, Swale and Thanet) and among certain groups in Kent. Given this, and the decline seen in smokers accessing cessation support, there is a need to consider innovative solutions to ensure achievement of the 2022 goals.









Significant variation in prevalence exists between districts, with the estimated prevalence in Thanet (23.7%) significantly greater than national estimated prevalence of 14.9% and Kent. As the data is survey based and only a sample of the whole population, there are large confidence intervals meaning a particularly large difference needs to be observed for statistical significance.





Source: Annual Population Survey (APS), prepared by KPHO (RK), Jul-18

Nationally, smoking prevalence has declined the quicker in the younger age groups, suggesting a lower uptake amongst the young, or e-cigarette use as an alternative choice which is not included in smoking figures. Regression analysis taken from smoking data in the ONS published Opinions and Lifestyle Survey<sup>20</sup> shows significant declines in all age groups, most notably in 25-34 age group since the year 2000. The table below shows the annual prevalence changes for three time points to the latest 2018 data. The 2018 data unusually showed that 16-24 year olds were the most prevalent age group, however the data is survey based and more year's data will be needed to see if this was an anomaly.

Table 21: Annual smoking prevalence changes from regression model by age band	,
England	

Annual smoking prevalence change (annual % change between years shown)	16-24	25-34	35-49	50-59	60 and over
2000-2018	-0.72	-0.78	-0.63	-0.63	-0.36
2009-2018	-0.41	-0.52	-0.67	-0.64	-0.53
2014-2018	0.36	-1.13	-0.22	0.01	-0.29

Figure 320: Smoking prevalence by age band, England

<sup>20</sup> 

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/d atasets/adultsmokinghabitsingreatbritain



# 9.3.2 Mortality

Respiratory disease has been discussed in chapter 11.3, but premature mortality is frequently associated with smoking and is one of the leading causes of death in the under 75s. Mortality considered 'preventable' are deaths that could potentially have been avoided by public health interventions in the broadest sense.

The graphs below show the indicators for premature mortality from respiratory diseases, and the mortality considered preventable. Dover, Swale and Thanet districts all have significantly higher rates of mortality and preventable mortality than Kent. It's likely most of the preventable mortality can be attributed to smoking, although a proportion can be attributed to other factors as well e.g. air pollution.





Figure 322 below shows the proportion of respiratory mortality that is considered preventable by district. In the East Kent districts, Ashford, Dover, Swale, and Thanet have a higher proportion of mortality that could be potentially avoided.



Figure 322: Proportion of respiratory mortality considered preventable

# 9.3.3 Smoking in Pregnancy

Smoking in pregnancy is associated with a wide range of problems, including complications during labour, increased risk of stillbirth, miscarriage, premature birth, low birth weight and sudden unexpected death in infancy<sup>21</sup>. In fact, smoking has been cited as the biggest single modifiable risk factor for poor birth outcomes. Smoking during pregnancy has been estimated to increase the risk of infant mortality by 40%<sup>22</sup>. In Kent between 2014-16, there were an estimated 233 stillbirths and 125 neo-natal mortalities attributable to smoking<sup>23</sup>.

Smoking in pregnancy further perpetuates the health inequalities seen in the general population. Smoking among disadvantaged groups and mothers under 20 is considerably higher than their affluent and older counterparts; prevalence among women in routine and manual occupations is five times higher than women in managerial and professional occupations. In addition, children who grow up with a parent that smokes are more likely to

<sup>&</sup>lt;sup>21</sup> NICE Guidelines: Smoking: stopping in pregnancy and after childbirth.

https://www.nice.org.uk/guidance/ph26/resources/smoking-stopping-in-pregnancy-and-after-childbirth-pdf1996240366789

<sup>&</sup>lt;sup>22</sup> National Maternity Review. Better Births: Improving outcomes of maternity services in England. A five year forward view for maternity care, 2014: <u>https://www.england.nhs.uk/wp-content/uploads/2016/02/nationalmaternity-review-report.pdf</u>

<sup>&</sup>lt;sup>23</sup> Fingertips: Local Tobacco Control Profile for Kent. Accessed October 2018 https://fingertips.phe.org.uk/profile/tobacco-control

be exposed to second-hand smoke and more likely to become addicted themselves, further perpetuating the cycle of inequality<sup>24</sup>.

Smoking in pregnancy remains a priority with NHS Digital recently estimating 14.2% (2,737) of women smoking at time of delivery (SATOD) in Kent & Medway in 2018/19, significantly higher than the national rate of 10.6%. It is believed attainment of smoking status in pregnancy has improved in the last few years due to the work of smoking in pregnancy midwives and CO monitoring at booking. However, concerns remain and there is a need to ensure a single effective SATOD measurement is in place for Kent.



## Figure 323: Smoking at time of delivery, Kent CCGs

Recent SATOD trends suggest a need to accelerate quits among smoking pregnant women to achieve 6% prevalence by 2022. Projections based on 2017/18 data at district level estimated reductions of 2.1% were needed each year to meet this target. There were an estimated 2,372 women smoking in pregnancy in Kent in 2017/18; the target is to reduce the annual number to 971 by 2022 to achieve 6%. Per year, this translates to an average target reduction of 350 women.

The STP aim to reduce Smoking in Pregnancy rates by improving CO monitoring and referral outcomes of the babyClear programme in maternity services, supported by specialist midwifery leads and implement the Home Visit Stop Smoking Adviser model across the whole of Kent and Medway.

<sup>&</sup>lt;sup>24</sup> Smoking in the Home: New solutions for a Smokefree Generation. Nov 2018 <u>http://ash.org.uk/wpcontent/uploads/2018/11/FINAL-2018-Smokefree-Housing-report-web.pdf</u>

## 9.3.4 Smoking Cessation

The smoking landscape has changed. A decline in the rates of referral to traditional stop smoking services has occurred alongside a concurrent increase in the use of e-cigarettes. Smoking cessation remains highly cost effective. With a 'number needed to treat' (NNT) value of 20 to prevent a premature death, it compares extremely favourably with other routine medical interventions.

Alongside this shift, the use of e-cigarettes is widespread, PHE report use of e-cigarettes has plateaued to just under 3 million people in England, the majority of whom have either quit smoking or are using vaping as a tool to quit. An additional three quarters of a million have quit both vaping and smoking<sup>25</sup>. The latest evidence presented by the Royal College of Physicians<sup>26</sup> finds e-cigarettes 95% safer for users than tobacco smoking. Cessation services are not promoting e-cigarette use but are supporting successful quit attempts by which ever choice smokers make.

While traditional smoking cessation services continue to offer smokers the best chance of quitting, there has been a decline in the rates of referral to these services both locally and nationally<sup>27</sup>. An estimated two-thirds of smokers report a desire to quit, yet just over 3% of the Kent smoking population currently access existing cessation services. There is a need to broaden support services to appeal to a wider audience.

National research by ASH<sup>28</sup> into the ways people quit smoking suggest the largest group of quitters may do so with e-cigarette assistance. The model applied to Kent suggest 5% of smokers typically quit each year (9,154 for Kent). Of these, 10% quit through core and NRT supported services. An estimated 41% could quit with e-cigarette assistance, 35% with no product or support, and 14% with other forms of NRT. However, despite low proportions of quitters going though supports services, these services play key roles in supporting a significant number of people and remain a key priority of the K&M STP.

Research has shown GPs have a particularly important role to play in encouraging and supporting quit attempts. Smokers are more likely to visit their GP than non-smokers, and data shows quit attempts are more likely if advice or support on smoking cessation is offered by a GP. Guidance also emphasises the need for patient choice. Allowing a smoker to choose the quit method they prefer, provided it is not a pharmacotherapy that is unsuitable for them, is likely to increase chances of success. Given this, Smoking+, an evidence-based Stop Smoking model developed by UCL Professor Robert West, appears to

<sup>&</sup>lt;sup>25</sup> PHE Health matters report 2018. Stopping smoking: What works?

<sup>&</sup>lt;sup>26</sup> <u>https://www.rcplondon.ac.uk/projects/outputs/nicotine-without-smoke-tobacco-harm-reduction-0</u>

<sup>&</sup>lt;sup>27</sup> Towards a Smokefree Generation: A Tobacco Control Plan for England. July 2017

https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-planforengland

<sup>&</sup>lt;sup>28</sup> <u>http://ash.org.uk/wp-content/uploads/2019/06/The-End-of-Smoking\_final.pdf</u>

offer the best chance of success, a model that offers three tiers of support. It is currently being trialled in Ashford CCG.

## 9.3.5 Link to the COPD Pathway

See Section on COPD (section 10.3.2 pp 282) The fig 324 below shows that South Kent Coast and Thanet have more people than the Kent average with COPD registered with primary care. This gives an opportunity to tackle smoking and respiratory disease.



#### Fig 324

Source: QOF, prepared by KPHO (RK), Jan-19

#### Figure 325: The Smoking+ model



# **Conclusion:**

Smoking remains the leading cause of preventable illness and preventable death in England and a significant public health challenge. It also accounts for a large proportion of the differences in health outcomes seen in the most and least deprived sections of the population.

Overall, smoking rates nationally and in Kent are falling and prevalence in Kent is now at 15%, 3% above the national reduction target of 12% prevalence by 2022. Smoking in younger people (or lack of uptake) is thought to be reducing at a faster rate than in older age groups.

Smoking in pregnancy remains a significant problem in Kent, currently measured at 14.4% at time of delivery compared to 10.8% in England, and is also strongly correlated with deprivation. The problem is particularly significant in South Kent Coast and Thanet CCGs.

Traditional supported smoking cessation services remain an important option for many people to successfully quit, and public health will continue to fully support use of NRT and e-cigarettes as aids to quit.

## **Recommendations:**

- Continue to commission specialist stop smoking services to increase the numbers of smokers supported to quit successfully
- Reduce Smoking in Pregnancy rates by improving CO monitoring and referral outcomes of the babyClear programme in maternity services and implementing the Home Visit Stop Smoking Adviser model across the whole of Kent and Medway (*STP Plan and NHS*

LTP 2.10)

- Support Kent and Medway Acute and Mental Health Trusts to provide direct stop smoking support
- Work innovatively with the private sector and other community settings to effectively support the public in the quit attempt where they wish to quit alone without the support of traditional core services
- Encourage GPs and other frontline workers to develop routine CO monitoring and encourage smoking cessation services for patients
- Work with Youth and Education services to encourage, motivate and support young people to quit smoking
- Promote Smoke Free environments as part of the social norm and promote Smokefree campaigns

# 9.4 Adult Obesity, Diet and Physical Activity

Obesity can contribute to a range of health conditions such as hypertension, type 2 diabetes and heart disease. Obesity is a general issue requiring collective effort from all stakeholders.

Excess weight is recorded in two surveys, the Active Lives Survey<sup>29</sup> which measures excess weight, combining overweight (25 to 30 BMI) and obesity (>30 BMI) and the Health Survey for England<sup>30</sup> which just measures obesity. As such they are only estimates and are subject to wide margins of error when applied to whole populations. Obesity is also recorded in GP QOF data, but is not considered complete enough for robust analysis.

The latest figures from the Active Lives Survey suggest that 62.8% of adults in Kent have excess weight. Whilst excess weight levels in Dover and Thanet are above the Kent average (71.4% and 70.3%), Canterbury district has excess weight levels below the Kent average (54.7%).

<sup>&</sup>lt;sup>29</sup> https://www.sportengland.org/research/active-lives-survey/

<sup>&</sup>lt;sup>30</sup> https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england


Figure 326: Estimated numbers of adults with excess weight, Kent districts 2017/18

Source: Public Health England (based on Active Lives survey, Sport England), prepared by KPHO (LLY), May-19

The Health Survey for England 2017 estimates that 30% of females and 27% of males age 16+ are obese in the South East region. This equates to approximately 88,000 females and 74,000 males across East Kent. The graphs below show modelled estimates of the changing patterns of obesity taken from the survey from 2014 to 2017.







# 9.4.1 Fruit and Vegetable Consumption

Consumption of five portions of fruit and vegetable is the recommended minimum daily amount to help maintain good health. It is used as a lifestyle indicator of health as it is closely associated with obesity and its associated issues, and also linked to deprivation because of availability, affordability and education.

The latest figures from the Active Lives Survey for 2017-18 suggest that 57% of adults in Kent meet the recommended '5-a-day' on a 'usual day', compared to around 55% nationally. Fruit and vegetable consumption is higher than the Kent average in Canterbury and Folkestone & Hythe districts.



## Figure 329: Fruit and vegetable consumption in adults – by district

Source: Public Health England (based on Active Lives, Sport England), prepared by KPHO (SR), Jun-19

# 9.4.2 Physical Inactivity

Physical inactivity is defined as doing less than 30 minutes of moderate physical activity per week. The latest self-reported figures from the Active Lives Survey for 2017-18 suggest that 20% of adults in Kent are physically inactive, compared to 22% nationally. There is evidence to suggest that physical inactivity is higher than the Kent average in Thanet. The remaining East Kent districts have similar levels of inactivity to the Kent average.

# Figure 330: Physical inactivity in adults – by district

### Physical inactivity in adults: by district



Percentage of adults (aged 19+) that are physically inactive (<30 moderate intensity equivalent minutes per week), 2017/18

Source: Public Health England (based on Active Lives, Sport England), prepared by KPHO (SR), Jun-19

# **Conclusion:**

Adult excess weight is an increasing national problem which is likely to need an increasing proportion of the healthcare budget to tackle the consequences. Survey data suggests 62.8% of people in Kent are overweight, with Thanet, Dover and Ashford districts all having higher proportions of the adult population with excess weight than the Kent average. Regional survey data suggest 27-30% of the population are obese across East Kent, which are more likely to have health implications. This equates to upwards of 150,000 adults. Although obesity is viewed in society as a personal problem – obesity is a clinical condition. Seen solely as an individual's issue and stigmatised – it can lead to inactivity by both health and care services as well as by people themselves.

- 40% of Obese people have no other long-term condition.
- Around 25% of obese people also have a second long-term condition
- 10% and nearly 20% respectively have two and three other co-occurring long-term conditions
- Most common co-morbidities are depression, Hypertension and Asthma.

Currently far more could be done for people suffering from obesity.

- Mostly programmes for obesity are delivered on childhood obesity
- There are some limited family projects
- Some local cooking and eating and healthy walks projects
- These projects are not particularly monitored in primary care

### **Recommendations from Best Practice in Tackling Obesity**

- Prevent it via reducing childhood obesity
- NO SILVER BULLET: Needs whole system change re availability of poor nutrition

- Limit screen time and increase activity
- Add coaching and counselling
- Add Workplace support
- Note link to depression and hypertension pathways
- Do not stigmatise the obese person but do tackle the subject head on.

# **Recommendations:**

- Work with District Councils and other partners to provide affordable fresh produce.
- Commission services to support individual behaviour change for adopting a healthy lifestyle in areas with lower consumption rates of '5-a-day'

# **Recommendations:**

- Empowering the population to reach a healthy weight will prevent a host of vascular and MSK related problems in the population over time and can be achieved with **proactive primary care** approaches to those registered as high BMI. The use of identification, advice and ongoing support within a care plan can be trialled with at risk groups or **overweight diabetics or overweight and depressed**. Offer Counselling and coaching.
- Training staff to have supportive and sometimes difficult conversations (as well as persistent) is important.
- Understanding that the public must be partners in a new contract with their clinicians to help keep them well can be built in to the practice / patient relationship and supported via public health and digital marketing approaches.
- Understanding the long term and personalised nature of this condition via social prescribing and community approaches will be important.

# **10** | Healthcare Utilisation and Disease Distribution

# **10.1 Health Checks**

Local Authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74 years once every five years.

The Health Check programme aims to prevent cardiovascular disease (heart disease, stroke, diabetes) and kidney disease. The programme also seeks to raise awareness of dementia in persons aged 65-74.

Because the Health Check programme is aimed at preventing disease, people with previously diagnosed vascular disease or who meet the exclusion criteria below are excluded from the programme.

Exclusion criteria:

- coronary heart disease
- chronic kidney disease
- diabetes
- hypertension
- atrial fibrillation
- transient ischaemic attack
- hypercholesterolemia
- heart failure
- peripheral arterial disease
- stroke
- prescribed statins
- people who have previously had a Health Check or any other check in England and found to have a 20% or higher risk of developing cardiovascular disease over the next ten years (QRISK2).

In keeping with the national aspiration to reach vulnerable groups, The Kent Health Check programme operates an outreach element which aims to target people from the most deprived areas of the county (i.e. quintiles 1 and 2 using the 2015 Index of Multiple Deprivation score).

In line with patterns observed across the country, uptake of NHS Health Checks is well below 100% in Kent. Kent Health Check Performance at practice level, relative to a 1-year eligible cohort, indicates an overall performance level of 39.3% for 2018/19. The underlying reasons for current performance levels are well understood and are governed by affordability and service infrastructure constraints that are apparent across the country.

The Kent Public Health Observatory have recently completed an equity audit of the NHS Health Check Programme, with full results available <u>here</u>.

It is of note, from this audit, that uptake of Health Checks vary by socio-economic status, in this case measured by ACORN, which is a consumer classification tool that helps to contextualise the attributes of households and postcodes. The ACORN classifications are based on demographic, socioeconomic, population and consumer behaviour and are used provide insights into people's behaviour, lifestyle and attitudes. When taken together these insights can be used to shed light on how services are provided and deployed making them more accessible to people who need them.

Within Kent, persons categorised by household types 'Affluent Achievers' and 'Comfortable Communities' are more likely to complete a Health Check when compared with persons categorised as being 'Financially Stretched' or in 'Urban Adversity'. The group type 'Rising Prosperity' showed no effect one way or the other.



Figure 331: Odds ratio of completing a Health Check by ACORN type (persons)

Work from the equity audit suggests an assessment of the numeric scale of this inequity should be conducted and appropriate channels of communication should be applied to redress the inequity gradient

# **ACORN CACI category descriptions**

# **Affluent Achievers**

These are some of the most financially successful people in the UK. They live in wealthy, high status rural, semi-rural and suburban areas of the country. Middle aged or older people, the 'baby-boomer' generation, predominate with many empty nesters and wealthy retired. Some neighbourhoods contain large numbers of well-off families with school age children, particularly the more suburban locations.

# **Rising Prosperity**

These are generally younger, well educated, and mostly prosperous people living in our major towns and cities. Most are singles or couples, some yet to start a family, others with younger children. Often these are highly educated younger professionals moving up the career ladder.

# **Comfortable Communities**

This category contains much of middle-of-the-road Britain, whether in the suburbs, smaller towns or the countryside. All life stages are represented in this category. Many areas have mostly stable families and empty nesters, especially in suburban or semi-rural locations. There are also comfortably well-off pensioners, living in retirement areas around the coast or in the countryside and sometimes younger couples just starting out on their lives together.

# **Financially Stretched**

This category contains a mix of traditional areas of Britain. Housing is often terraced or semi-detached, a mix of lower value owner occupied housing and homes rented from the council or housing associations, including social housing developments specifically for the elderly. This category also includes student term-time areas. There tends to be fewer traditional married couples than usual and more single parents, single, separated and divorced people than average.

# **Urban Adversity**

This category contains the most deprived areas of large and small towns and cities across the UK. Household incomes are low, nearly always below the national average. The level of people having difficulties with debt or having been refused credit approaches double the national average. The numbers claiming Jobseeker's Allowance and other benefits is well above the national average. Levels of qualifications are low and those in work are likely to be employed in semi-skilled or unskilled occupations.

# **10.2** Diabetes

Diabetes poses a major public health challenge for the local population. It is a significant cause of morbidity. Diabetes reduces the life expectancy of people with type 1 by about 15 years and type 2 by about 10 years. If not well managed individuals with diabetes could have co-morbidities resulting in complications such as:

Diabetic emergencies: Hypoglycaemia, diabetic ketoacidosis, other diabetic comas

**Chronic complications:** blindness, kidney disease, coronary heart disease, foot ulcers, amputations, and neuropathy.

Many of these complications are preventable or controllable through sensible lifestyle modifications such as weight and diet, which allow better control of blood glucose levels, high blood pressure and blood cholesterol. Routine screening such as diabetic retinal screening can also help prevent diabetic complications such as glaucoma.

In East Kent, the QOF recorded diabetes prevalence in South Kent Coast and Thanet CCGs is significantly higher than the Kent average, and Ashford and Canterbury & Coastal are below the Kent average. There is significant variation in recorded prevalence between wards, with 5 wards in East Kent with a prevalence above 8% in their adult population, and the majority of wards in South Kent Coast and Thanet CCGs above 7%. By contrast, no wards in Ashford CCG were above 7% prevalence.





Source: PCIS, prepared by KPHO (MP), Apr-19

# Figure 333: Recorded diabetes prevalence – by Ward

# Premetree Recentants as a line to a space of the space o

Recorded diabetes prevalence: by electoral ward

Source: QOF, prepared by KPHO (MP), Nov-18

# Figure 334



### Recorded diabetes prevalence: by electoral ward

Percentage of patients aged 17+ recorded on GP QOF registers as having diabetes mellitus, modelled ward-level estimates, 2015/16-2017/18



### Figure 336

### Recorded diabetes prevalence: by electoral ward

Percentage of patients aged 17+ recorded on GP QOF registers as having diabetes mellitus, modelled ward-level estimates, 2015/16-2017/18



Recorded diabetes is increasing at roughly a 0.1% prevalence increase per year across Kent and is fairly consistently increasing across the four East Kent CCGs.





Source: QOF, prepared by KPHO (MP), Nov-18

Obesity is one of the risk factors for type 2 diabetes. There is high variation in recorded obesity prevalence across practices and is not considered an accurate representation of the true obesity level.

# Figure 338: Recorded prevalence of obesity: by CCG

**Recorded prevalence of obesity: by CCG** 





Source: QOF, prepared by KPHO (RK), Jan-19

The rate of emergency admissions to hospital for diabetes, for example for hypoglycaemia, diabetic ketoacidosis, etc. in South Kent Coast and Thanet CCGs is higher than the Kent average. There is significant variation across wards, with the following wards having significantly higher emergency hospital admission rates than the Kent average.

### Ashford CCG:

- Stanhope
- Aylesford Green

### Canterbury & Coastal CCG:

- Wincheap
- Northgate
- St Ann's
- Chartham & Stone Street
- Barton

### South Kent Coast CCG:

- Hythe Central
- Folkestone Morehall

- Tower Hamlets
- New Romney Coast
- St Radigunds
- Aylesham

### Thanet CCG:

- Margate Central
- Newington
- Northwood
- Westbrook
- Beacon Road
- Cliftonville West
- Cliftonville East

### Figure 339: Emergency hospital admissions for diabetes – by CCG (of residence)

Age standardised rate per 100,000 resident population, ICD 10: E10-14 (primary diabnosis), 2013/14-2017/18 CCG — Kent 450 Age standardised rate per 100,000 relevant resident population 66.5 400 92.5 01. 350 300 250 200 150 100 50 0 Canterbury and Coastal Dartford, Gravesham CCG and Swanley CCG Ashford CCG South Kent Coast CCG Swale CCG Thanet CCG West Kent CCG

Emergency hospital admissions for diabetes: by CCG

Health needs assessment: East Kent, August 2020

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Nov-18

# Figure 340: Emergency hospital admissions for diabetes - by ward



### Emergency hospital admissions for diabetes: by electoral ward

Age standardised rate per 100,000 resident population, ICD 10: E10-14 (primary diagnosis), 2013/14-2017/18

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Nov-18

### Figure 341



# Emergency hospital admissions for diabetes: by electoral ward

Age standardised rate per 100,000 resident population, ICD 10: E10-14 (primary diagnosis), 2013/14-2017/18

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Nov-18

### Emergency hospital admissions for diabetes: by electoral ward

Age standardised rate per 100,000 resident population, ICD 10: E10-14 (primary diagnosis) , 2013/14-2017/18



### Figure 343

# Emergency hospital admissions for diabetes: by electoral ward

Age standardised rate per 100,000 resident population, ICD 10: E10-14 (primary diagnosis), 2013/14-2017/18



# **Conclusion:**

There are currently close to 40,000 patients with a diagnosis of diabetes across East Kent. There is considerable variation in the recorded prevalence of diabetes across East Kent ranging from a high of 10.9% to 3 - 4% in areas with a younger or student populations. Recorded obesity rates vary even wider, ranging from a high of 21.9% to a low of 3.1% (over 50,000 patients) but this is thought to be an underestimate of the true value circa 25% – 30%, see chapter 10.4.

Both diabetes and obesity rates are both predicted to increase. If recent trends continue, type 2 diabetes prevalence is increasing by 0.1% per year, equating to around 900 more patients annually across East Kent.

There is a deprivation gap of around 2% (25-30% higher) between the most and least deprived quintiles in Kent. Both are increasing in prevalence at a similar rate.

# **Recommendations:**

- There needs to be greater activity with respect to prevention which needs to be grounded in local interventions rather than just giving advice. Interventions need to be able to identify undiagnosed diabetics as well as the cohort of patients inadequately supported in Primary Care.
- There needs to be greater emphasis on obesity given the relationship BMI shares with diabetes.
- Optimizing health checks to 'find the missing thousands' and for referral into lifestyle programs to reduce risks.
- Secondary prevention for people with diabetes is important to prevent complications. Local primary care providers of care should be made aware of rates of emergency admissions for diabetic complications and structure services accordingly.
- All diabetes patients except those with existing eye conditions and under the care of a specialist should attend annual screening to prevent retinopathy.
- Specialized services such as education, podiatry, dietetics and psychology require additional support to ensure equitable access across West Kent, in anticipation of the predicted rise in increasing numbers of people who will be diagnosed with diabetes.

# **10.3 Respiratory Diseases**

Asthma and Chronic Obstructive Pulmonary Disease are the two most common chronic lung diseases and are both recorded in the GP quality and outcomes framework. Lung diseases can affect an individual's level of mobility and also their activities of daily living. Patients with advanced COPD can result in significant years of life lost or lived in disability.

# 10.3.1 Asthma

Asthma affects both children and adults and is one of the most common chronic conditions. The recorded prevalence of asthma for all four East Kent CCGs are significantly above the Kent average of 5.5%, with Thanet CCG highest at 5.9%. The wards listed below are significantly higher than the recorded prevalence for their CCG:

# Ashford CCG:

- Bybrook
- Weald South
- Bockhager
- Little Burton Farm
- Kennington
- Boughton Aluph & Eastwell

Canterbury CCG:

- Tankerton
- Harbour
- Chestfield and Swalecliffe
- Seasalter
- Gorrell
- Reculver
- West Bay
- Greenhill & Eddington

- Heron
- Little Stour & Ashstone
- Herne and Broomfield
- Boughton & Courtenay
- Watling
- Abbey

# South Kent Coast CCG:

- New Roney Town
- Lydd
- Lydden and Temple Ewell
- New Romney Coast
- Folkestone Harvey West

# Thanet CCG:

• Thanet Villages





Source: QOF, prepared by KPHO (RK), Jan-19

# Figure 345: Recorded asthma prevalence - by Ward



### Recorded asthma prevalence: by electoral ward

Percentage of patients recorded on GP QOF registers as having Asthma, modelled ward-level estimates, 2015/16-2017/18



### Figure 347

# Recorded asthma prevalence: by electoral ward

Percentage of patients recorded on GP QOF registers as having Asthma, modelled ward-level estimates, 2015/16-2017/18





The rate of emergency admissions to hospital for asthma is significantly higher than the Kent average in Canterbury and Coastal CCG, and similar to Kent in the other three East Kent CCGs. There is significant variation across wards, with the following having significantly higher emergency hospital admission rates than the Kent average:

Ashford CCG:

- Beaver
- Stanhope
- Stour

Canterbury & Coastal CCG:

- Little Stour
- Greenhill & Eddington
- Northgate
- Davington Priory
- West Bay
- Boughton & Courtenay
- Heron
- Watling

- Abbey
- Barton

South Kent Coast CCG:

- Hythe West
- Town and Pier
- Romney Marsh
- Hythe Central
- Aylesham

# Thanet CCG:

- Nethercourt
- Dane Valley



# Figure 349: Emergency hospital admissions for asthma – by CCG (of residence)

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Jan-19

### Figure 350: Emergency hospital admissions for asthma – by ward



### Emergency hospital admissions for asthma: by electoral ward

Age-standardised rate per 100,000 registered population, ICD 10: J45-J46 (primary diagnosis), 2013/14-2017/18

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Jan-19



### Emergency hospital admissions for asthma: by electoral ward

Age-standardised rate per 100,000 registered population, ICD 10: J45-J46 (primary diagnosis), 2013/14-2017/18

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Jan-19

Figure 352

### Emergency hospital admissions for asthma: by electoral ward

Age-standardised rate per 100,000 registered population, ICD 10: J45-J46 (primary diagnosis), 2013/14-2017/18



Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Jan-19

### Figure 353



Emergency hospital admissions for asthma: by electoral ward

Age-standardised rate per 100,000 registered population, ICD 10: J45-J46 (primary diagnosis), 2013/14-2017/18

There is only a marginal and non-significant difference in deprivation for recorded asthma in Kent, with both the most and least deprived quintiles remaining the similar level over the last 5 years, similar to changes seen nationally.



### Figure 354: Recorded prevalence of Asthma: deprivation

Source: QOF, prepared by KPHO (MP), Nov-18

# 10.3.2 Chronic Obstructive Pulmonary Disease (COPD)

COPD is a general term that is used to describe a number of conditions, including chronic bronchitis and emphysema. The primary cause of COPD is smoking.

Recorded COPD prevalence in South Kent Coast and Thanet CCGs are significantly higher than the Kent average, and lower than average in Ashford and Canterbury & Coastal CCGs. There is high variability across practices. The wards listed below are significantly higher than the mean recorded prevalence for their CCG:

Ashford CCG:

- St Michaels
- Tenterden South
- Weald Central
- Tenterden North
- Isle of Oxney
- Weald South
- Weald North
- Biddenden

Rolvenden & Tenterden West

Canterbury CCG:

- Eastry
- Little Stour & Ashstone
- Sandwich
- St Ann's
- Herne & Broomfield
- Heron
- Greenhill & Eddington

- West Bay
- Seasalter
- Reculver
- Gorrell

South Kent Coast CCG:

- Aylesham
- Dymchurch & St Mary's Bay
- New Romney Town
- Lydd
- St Margaret's-at-Cliffe

- Eastry
- North Deal
- Mill Hill

Thanet CCG:

- Birchington South
- Northwood
- Newington
- Birchington North
- Thanet Villages





Recorded prevalence of COPD: by CCG

Percentage of patients (all ages) recorded on GP QOF registers as having COPD, 2017/18

Source: QOF, prepared by KPHO (RK), Jan-19

# Figure 356: Recorded COPD prevalence – by Ward



Source: QOF, prepared by KPHO (MP), Nov-18

### **Recorded COPD prevalence: by electoral ward**



Source: QOF, prepared by KPHO (MP), Nov-18

### Figure 358

### **Recorded COPD prevalence: by electoral ward**

Percentage of patients recorded on GP QOF registers as having COPD Percentage of patients recorded on GP QOF registers as



Source: QOF, prepared by KPHO (MP), Nov-18

### Figure 359

### **Recorded COPD prevalence: by electoral ward**

Percentage of patients recorded on GP QOF registers as having COPD Percentage of patients recorded on GP QOF registers as having COPD



Source: QOF, prepared by KPHO (MP), Nov-18

The prevalence of diagnosed COPD is increasing at around 0.07% per year across Kent. There is a large disparity in the prevalence between the most and least deprived quintiles, with a circa 75% higher prevalence in the most deprived. The rate of prevalence increase is roughly double in the most deprived than the least, at 0.1% per year.



# Figure 360: Recorded COPD prevalence: deprivation

Source: QOF, prepared by KPHO (MP), Nov-18

The rate of emergency admissions to hospital for COPD in Canterbury & Coastal, South Kent Coast and Thanet CCGs are higher than the Kent average, and below the Kent average in Ashford CCG. There is considerable variation between electoral wards. Emergency hospital admission rates for COPD are significantly higher than the Kent average in:

Ashford CCG:

- Beaver
- Norman
- Stanhope
- Boughton Aluph & Eastwell
- Aylesford Green
- Washford
- Park Farm South

Canterbury & Coastal CCG:

- Northgate
- Wincheap
- Sturry North

- Heron
- Teynham & Lynsted
- Westgate
- West Bay

South Kent Coast CCG:

- St Radigunds
- Aylesham
- Buckland
- Folkestone East
- Town & Pier
- Tower Hamlets
- Folkestone Foord

Thanet CCG:

- Margate Central
- Newington
- Dane Valley

- Northwood
- Cliftonville West
- Salmestone



# Figure 361: Emergency hospital admissions for COPD – by CCG (of residence)

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (ZC), Nov-18

# Figure 362: Emergency hospital admissions for COPD – by ward



Emergency hospital admissions for COPD: by electoral ward

Age standardised rate per 100,000 adults aged 35+, ICD 10: J40-44 (primary diagnosis), 2013/14-2017/18

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (ZC), Nov-18

### Figure 363



Emergency hospital admissions for COPD: by electoral ward Are standardised rate per 100.000 adults ared 35+. ICD 10:140-44 (primary diagnosis). 2013/14-2017/18

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (ZC), Nov-18

### Emergency hospital admissions for COPD: by electoral ward

Age standardised rate per 100,000 adults aged 35+, ICD 10: J40-44 (primary diagnosis), 2013/14-2017/18



Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (ZC), Nov-18

### Figure 365



Age standardised rate per 100,000 adults aged 35+, ICD 10: J40-44 (primary diagnosis), 2013/14-2017/18



Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (ZC), Nov-18

Based on estimates of disease counts calculated using a logistic regression model developed by Imperial College based on CPRD, it is estimated that circa 0.8% of the registered population in East Kent have undiagnosed COPD. The research suggests Ashford, Canterbury & Coastal and South Kent Coast CCGs may have slightly higher rates of undiagnosed COPD than the rest of Kent.

When looked at by practice, the model suggests as many as 2.3% of some practices' populations could be undiagnosed.



# Figure 366: Undiagnosed COPD (estimated) – by CCG

Source: Imperial College London/QOF, prepared by KPHO (RK), Jan-19

# Figure 367: Undiagnosed COPD (estimated) – by GP practice



### Undiagnosed COPD (estimated): by GP practice

Modelled estimates of the prevalence of undiagnosed COPD, 2015, recorded prevalence of COPD, 2017/18

Source: Imperial College London/QOF, prepared by KPHO (RK), Jan-19

### Figure 368



Undiagnosed COPD (estimated): by GP practice

Modelled estimates of the prevalence of undiagnosed COPD, 2015, recorded prevalence of COPD, 2017/18

Source: Imperial College London/QOF, prepared by KPHO (RK), Jan-19



Source: Imperial College London/QOF, prepared by KPHO (RK), Jan-19





Modelled estimates of the prevalence of undiagnosed COPD, 2015, recorded prevalence of COPD, 2017/18



Source: Imperial College London/QOF, prepared by KPHO (RK), Jan-19
### **Conclusion:**

Both Asthma and COPD remain significant health problems for the Kent population, with over 40,000 diagnosed asthmatics currently at GPs registered in East Kent and 16,500 with COPD.

Variation in the recorded prevalence of asthma is low across East Kent, with the majority of the populace falling in the 5 - 6% range. COPD prevalence shows greater variation, with Thanet CCG around 45% higher prevalence than Ashford CCG.

Asthma prevalence is largely static in East Kent, although still accounting for high volumes of patients with an annual prevalence increase of around 0.01% since 2012-13, or 450 patients per year. COPD prevalence is increasing more rapidly, at around a 0.07% increase; an additional 600 patients per year.

Deprivation differences are marginal for asthma but are present and widening for COPD which is increasing at double the rate in the most deprived areas than the least.

Rates of emergency admissions should be monitored for both conditions, especially in practices in the lower or higher prevalence areas.

# **Recommendations:**

# Asthma

To undertake targeted work with practices with low prevalence of Asthma and high admission rates and explore if patients could be better managed in primary care.

# COPD

Active case finding for individuals with COPD should encouraged.

COPD should be considered in patients over the age of 35 who have a risk factor (generally smoking) and who present with exertional breathlessness, chronic cough, regular sputum production, frequent winter 'bronchitis' or wheeze.

All COPD patients still smoking, regardless of age should be encouraged to stop, and offered help to do so, at every opportunity.

Pulmonary rehabilitation should be made available to all appropriate people with COPD including those who have had a recent hospitalization for an acute exacerbation.

Practices should understand local variation in the management of individuals with COPD and implement model of best practice.

# **10.4 Cardiovascular Diseases (CVD)**

CVD is a term used to describe disorders of heart and blood vessels. These diseases include Coronary Heart Disease, Coronary Artery Disease and Cerebrovascular disease which may lead to angina, heart failure and strokes.

# 10.4.1 Coronary Heart Disease (CHD)

Recorded CHD prevalence is higher than Kent in Canterbury & Coastal, South Kent Coast and Thanet CCGs, and similar to Kent in Ashford CCG. There is some variability across wards, the following show significantly higher rates than their CCG average:

Ashford CCG:

- Weald South
- Isle of Oxney
- St Michaels
- Weald Central
- Tenterden South
- Tenterden North
- Rolvenden & Tenterden West
- Weald North
- Biddenden
- Charing
- Saxon Shore

Canterbury & Coastal CCG:

- Reculver
- Eastry
- Greenhill & Eddington
- Heron
- Herne & Broomfield
- Sandwich
- Tankerton
- Chestfield & Swalecliffe
- Harbour

- Gorrell
- Seasalter

South Kent Coast CCG:

- Hythe West
- Hythe Central
- New Romney Town
- Hythe East
- Lydd
- Dymchurch & St Mary's Bay
- New Romney Coast
- Eastry
- North Deal
- Mill Hill
- Middle Deal & Sholden
- Walmer

# Thanet CCG:

- Birchington South
- Birchington North
- Thanet Villages
- Westgate-on-sea



Figure 371: Recorded coronary heart disease prevalence – by CCG (of registration)

Source: QOF, prepared by KPHO (RK), Jan-19

# Figure 372: Recorded coronary heart disease prevalence – by Ward



#### **Recorded CHD prevalence: by electoral ward**

Percentage of patients recorded on GP QOF registers as having coronary heart disease, modelled ward-level estimates, 2015/16-



#### Figure 374



Percentage of patients recorded on GP QOF registers as having coronary heart disease, modelled ward-level estimates, 2015/16-2017/18





The is a slight decrease in recorded CHD over time, with a measured decline of 0.04% per year. There is a small difference between the most and least deprived, with about a 10% higher prevalence in the most deprived and a similar rate of change.





Source: QOF, prepared by KPHO (MP), Nov-18

As with prevalence, recorded admissions for CHD is higher than Kent in Canterbury & Coastal, South Kent Coast and Thanet CCGs, and similar to Kent in Ashford CCG. There is moderate variation across wards, with the following significantly above their CCG average:

Ashford CCG:

- Bybrook
- Bockhanger
- Stanhope

Thanet CCG:

- Dane Valley
- Nethercourt

Canterbury & Coastal CCG:

- Heron
- Abbey

# Figure 377: Hospital admissions for coronary heart disease – by CCG (of residence)



#### Figure 378: Hospital admissions for coronary heart disease - by ward



Hospital admissions for Coronary Heart Disease (CHD): by electoral ward Age standardised rate per 100,000 resident population, ICD-10: I20-I25 (primary diagnosis), 2015/16-2017/18

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (MP), Nov-18

#### Figure 379



# Hospital admissions for Coronary Heart Disease (CHD): by electoral ward



Hospital admissions for Coronary Heart Disease (CHD): by electoral ward

Age standardised rate per 100,000 resident population, ICD-10: I20-I25 (primary diagnosis), 2015/16-2017/18

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (MP), Nov-18

#### Figure 381



Hospital admissions for Coronary Heart Disease (CHD): by electoral ward

# 10.4.2 Hypertension

Persistent hypertension is one of the risk factors for cardiovascular conditions such as stroke and heart failure and is also a major cause of chronic kidney disease. Chronic Kidney Disease could also be as a result from complications for individuals with diabetes. Hypertension is a common comorbidity with a range of other long-term conditions (see section 11.11 on multimorbidity).

Recorded hypertension prevalence is highly variable across Kent. Overall, South Kent Coast and Thanet CCGs are significantly higher than Kent, Ashford CCG is similar, and Canterbury & Coastal is significantly lower. There is variability across wards, the following show significantly higher rates than their CCG average:

Ashford CCG:

- St Michaels
- Biddenden
- Tenterden North
- Tenterden South
- Isle of Oxney
- Rolvenden & Tenterden West
- Weald North
- Weald South
- Weald Central
- Saxon Shore

# Canterbury & Coastal CCG:

- Sandwich
- Eastry
- Little Stour & Ashstone
- Reculver
- Herne & Broomfield
- West Bay
- Heron
- Greenhill & Eddington
- Seasalter
- Gorrell
- Tankerton
- Harbour
- Chestfield & Swalecliffe
- Barham Docks

South Kent Coast CCG:

- Hythe West
- New Romney Town
- Hythe Central
- New Romney Coast
- Lydd
- Dymchurch & St Mary's Bay
- Hythe East
- Eastry
- Lympne & Stanford
- Romney Marsh
- North Deal
- Ringwould
- Mill Hill
- North Downs East
- Middle Deal & Sholden
- Walmer
- Folkestone Sandgate
- Eyhorne & Shepherdswell
- Folkestone Morehall

# Thanet CCG:

- Birchington South
- Thanet Villages
- Birchington North
- St Peters



Recorded prevalence of hypertension: by CCG

# Figure 382: Recorded prevalence of hypertension – by CCG (of registration)

Source: QOF, prepared by KPHO (RK), Jan-19

### Figure 383: Recorded prevalence of hypertension – by Ward



# Recorded hypertension prevalence: by electoral ward

Percentage of patients recorded on GP QOF registers as having hypertension, modelled ward-level estimates, 2015/16-2017/18

#### Recorded hypertension prevalence: by electoral ward

Percentage of patients recorded on GP QOF registers as having hypertension, modelled ward-level estimates, 2015/16-2017/18



#### Figure 385





There is a 0.17% per annum increase in prevalence of hypertension per year in East Kent, which is modest for a high prevalence condition of around 15% in the population. There is only a small difference between the most and least deprived quintiles in Kent of around 6%, however the rate of increase is higher in the most deprived.

### Figure 387: Recorded prevalence of hypertension – by deprivation



Based on a predictive model developed by Imperial College London<sup>31</sup>, it is estimated that Thanet and South Kent Coast CCGs have a marginally higher rate of undiagnosed hypertension (13%) than Ashford (12.4%) and Canterbury and Coastal CCGs (11.7%).

Figure 388: Estimated prevalence of undiagnosed hypertension – by CCG (of registration)



Source: Imperial College London, prepared by KPHO (RK), May-18

## 10.4.3 Stroke

<sup>&</sup>lt;sup>31</sup> <u>https://github.com/julianflowers/prevalence\_estimates/blob/master/Hypertension-model-2016-Technical-Document-v2.5.docx</u>

Stroke services in Kent are currently subject to review and redesign with planned Hyperacute stroke units (HASU), which will offer the population of Kent more comprehensive care with teams of specialist stroke healthcare professionals.

Recorded prevalence of stroke and transient ischemic attack (TIA) is above the Kent average in Canterbury & Coastal, South Kent Coast and Thanet CCGs, and similar to Kent in Ashford CCG. Some of the leading risk factors for stroke such as diabetes, atrial fibrillation, hypertension, smoking and alcohol have been shown to be higher than the Kent average in some of the East Kent CCGs as well. There is variability across wards, the following show significantly higher rates than their CCG average:

Ashford CCG:

- Tenterden North
- Tenterden South
- St Michaels
- Rolvenden & Tenterden West
- Isle of Oxney
- Weald Central
- Biddenden
- Weald South
- Weald North
- Charing

Canterbury & Coastal CCG:

- Reculver
- Heron
- Herne & Broomfield
- Greenhill & Eddington
- West Bay
- Eastry
- Sandwich
- Tankerton
- Chestfield & Swalecliffe
- Harbour

- Gorrell
- Seasalter

# South Kent Coast CCG:

- Hythe West
- Hythe Central
- Hythe East
- Lydd
- New Romney Town
- New Romney Coast
- North Deal
- Mill Hill
- Middle Deal & Sholden
- Ringwould
- Folkestone Sandgate
- Walmer

# Thanet CCG:

- Birchington South
- Birchington North
- Thanet Villages
- Westgate-on-sea

# Figure 389: Recorded prevalence of stroke and TIA – by CCG (of registration)



Source: QOF, prepared by KPHO (RK), Jan-19

#### Figure 390: Recorded prevalence of stroke and TIA – by Ward

#### Recorded stroke and TIA prevalence: by electoral ward

Percentage of patients recorded on GP QOF registers as having Stroke or TIA, modelled ward-level estimates, 2015/16-2017/18





#### Recorded stroke and TIA prevalence: by electoral ward

Percentage of patients recorded on GP QOF registers as having Stroke or TIA, modelled ward-level estimates, 2015/16-2017/18



Source: QOF, prepared by KPHO (MP), Nov-18



#### Figure 393

#### Recorded stroke and TIA prevalence: by electoral ward

Percentage of patients recorded on GP QOF registers as having Stroke or TIA, modelled ward-level estimates, 2015/16-2017/18



The prevalence of recorded stroke in the population is largely static, with a marginal 0.02% prevalence increase per year in Kent. There are also negligible differences with depravation in Kent.



#### Figure 394: Recorded Stroke prevalence: by deprivation

Source: QOF, prepared by KPHO (MP), Nov-18

# 10.4.4 Atrial Fibrillation (AF)

Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate. It can cause fatigue, a shortness of breath and dizziness and is a risk factor for Stroke. The recorded prevalence of atrial fibrillation (AF) is above the Kent average in all four East Kent CCGs. There is variability across wards, the following show significantly higher rates than their CCG average:

Ashford CCG:

- Tenterden South
- Tenterden North
- St Michaels
- Rolvenden & Tenterden West
- Isle of Oxney
- Weald Central
- Weald South
- Biddenden
- Saxon Shore

### Canterbury & Coastal CCG:

- Tankerton
- Harbour
- Chestfield & Swalecliffe
- Gorrell
- Seasalter
- Eastry
- Reculver
- Sandwich
- West Bay
- Greenhill & Eddington
- Heron
- Herne & Broomfield

South Kent Coast CCG:

- Hythe West
- Hythe Central
- Hythe East
- New Romney Town
- Dymchurch & St Marys Bay
- New Romney Coast
- Folkestone Sandgate
- Lydd
- Ringwould
- Walmer
- Lympne & Stanford

- Eastry
- North Deal
- Middle Deal & Sholden
- Mill Hill

#### Thanet CCG:

- Birchington South
- Birchington North
- Westgate-on-sea
- Thanet Villages
- St Peters

### Figure 395: Recorded prevalence of atrial fibrillation – by CCG (of registration)



Recorded prevalence of atrial fibrillation: by CCG Percentage of patients (all ages) recorded on GP QOF registers as having atrial fibrillation, 2017/18

Source: QOF, prepared by KPHO (RK), Jan-19

#### Figure 396: Recorded prevalence of atrial fibrillation - by Ward



#### Recorded atrial fibrillation prevalence: by electoral ward

Percentage of patients recorded on GP QOF registers as having atrial fibrillation, modelled ward-level estimates, 2015/16-2017/18

Source: QOF, prepared by KPHO (MP), Nov-18

#### Figure 397

# Recorded atrial fibrillation prevalence: by electoral ward Percentage of patients recorded on GP QOF registers as having atrial fibrillation, modelled ward-level estimates, 2015/16-2017/18 Chestfield & Swalecliffe Greenhill & Eddington Herne & Broomfield







Percentage

Greater than 2.6 2.2 to 2.6 2.0 to 2.2 1.8 to 2.0 Less than 1.8

Source: QOF, prepared by KPHO (MP), Nov-18

Thanet Villages

The recorded prevalence of atrial fibrillation is increasing across Kent at just over 0.1% increase per year, equating to approximately 900 more patients per year across East Kent. The rate of change is roughly the same across the four CCGs, with a marginally higher increase seen in Thanet CCG and lower in Canterbury, and no significant differences in change were seen by deprivation. The overall prevalence is higher in the least deprived quintile of the population by around 20%.



#### Figure 400: Recorded prevalence of atrial fibrillation – by deprivation

Source: QOF, prepared by KPHO (MP), Nov-18

### **Conclusion:**

There are geographical variations in recorded prevalences of CVD related conditions, with the same wards typically showing the highest prevalences across all four conditions. We were not able to present the QoF data as age standardised rates, so age variations are likely to be the principle factor in the observed differences as all the conditions increase in prevalence with age.

The prevalence of CHD in the population is gradually falling, with around 24,000 recorded cases across East Kent, this number is likely to remain fairly static in the coming years as the population grows and ages. Hypertension is growing faster with a 0.15 – 0.2% increase per year in East Kent, equating to circa 2,000 more cases annually to add to the 111,000 already diagnosed. There are c.14,400 recorded cases of stroke and TIA in East Kent, with the overall prevalence increasing gradually by 0.02% or circa 250 – 300 more per year. Recorded atrial fibrillation appears to be increasing more rapidly, at around 0.1% per annuum or around 900 more cases.

Epidemiological differences have been observed with deprivation, with the prevalence of CHD and hypertension about 10% higher in most deprived quintile than the least in

Kent. No differences were seen by deprivation for stroke prevalence. Atrial fibrillation was more prevalent and has been growing faster in the least deprived quintile of the population in Kent, which may suggest an element of undetected atrial fibrillation in parts of the population.

# **Recommendations:**

Increase the uptake of health checks to identify persons with cardiovascular risks.

Four key areas of AF management should be addressed to improve outcomes in terms of stroke prevention:

- diagnosis of AF
- identification of those at high risk of stroke
- initiation of anticoagulant therapy in line with national guidelines
- maintenance of adequate anticoagulation / medicines optimisation

# 10.5 Cancer

A study<sup>32</sup>, published in 2018 showed that nearly four in ten (37.7%) cancer cases in 2015 in the UK were attributable to known risk factors. The proportion was around two percentage points higher in UK males (38.6%) than in UK females (36.8%). The important lifestyle factors that affect the incidence and mortality of cancer include tobacco smoking, alcohol excess, diet, obesity, infectious agents, environmental pollutants and radiation.

According to QOF GP register data, the recorded all-age non-melanoma cancer prevalence is higher in all four East Kent CCGs when compared to England that has an average prevalence of 2.7%. Ashford CCG is faring a little better than the others with a prevalence of 2.9% and is the only CCG to be under the Kent, Surrey and Sussex average of 3.1%.

<sup>&</sup>lt;sup>32</sup> British Journal of Cancer **118**, 1130–1141 (2018)

#### Figure 401: Recorded prevalence of cancer – by CCG (of registration)



#### Recorded cancer prevalence: by CCG

Source: QOF, prepared by KPHO (MP), Nov-18

There are an estimated 2.5 million people living with cancer in the UK in 2015, rising to 4 million by 2030<sup>33</sup>. This projected increase is being seen already in prevalence of all cancers increasing year on year since 2009/10, across England as a whole, and the four East Kent CCGs. England has increased from a percentage of patients registered under QOF GP data from 1.4% in 2009/10 to 2.7% in 2017/18. Ashford CCG has seen the smallest prevalence increase of the four East Kent CCGs from 1.6% to 2.9% equating to an increase of 2,600 patients, with Canterbury CCG increasing the most from 1.5% to 3.5%, around a 5,200 patient increase.

Across East Kent, 23,800 people were recorded as having cancer on the QoF for East Kent. Using regression analysis for the last 5 years the prevalence has been shown to be increasing at around 0.2 - 0.25% annually. This equates to circa 1,800 more per year.

The increasing prevalence of cancers is explained by changes over time occurring within the population. The biggest risk for developing cancer is age – and the population is getting older. In addition, more people are now living longer with cancer mainly due to medical advances in treating cancer. Both increase the overall prevalence of people living with

<sup>&</sup>lt;sup>33</sup>Maddams J, Utley M, Møller H. Projections of cancer prevalence in the United Kingdom, 2010-2040. Br J Cancer 2012; 107: 1195-1202

cancer. By 2040 older people will account for 77% of all people living with a cancer diagnosis, an increase from the 2015 figure of 66%<sup>34</sup>



Figure 402: Diagnosed cancer prevalence for East Kent CCGs: Trend

The graph below demonstrates that cancer is more prevalent in the least deprived quintile of the population by around 20 - 25%. This could be because the least deprived population live longer and therefore have a higher lifetime risk of developing cancer, or differences in prevalence of different types of cancer and the stages at which they are detected, and treatment commenced.

# Figure 403: Recorded cancer prevalence: deprivation

<sup>&</sup>lt;sup>34</sup> Maddams J, Utley M, Møller H. Projections of cancer prevalence in the United Kingdom, 2010-2040. Br J Cancer 2012; 107: 1195-1202.



Source: QOF, prepared by KPHO (MP), Nov-18

The graph below shows that the one-year net survival for all cancers, both in England and in all four CCGs is improving significantly. This means that more people are living with cancer. Notably, the one-year survival for Thanet CCG is lower than the other East Kent CCGs.

Figure 404: 1-year net survival for East Kent CCGs: Trend



All four East Kent CCGs, except Ashford are above the Kent average for hospital admissions

with cancer. Canterbury and Coastal CCG has the highest rate at 597.5 per 100,000 followed by Thanet CCG with 592.0 per 100,000.

#### Figure 405: Emergency Hospital Admissions: CCGs



Emergency hospital admissions with cancer: by CCG

Age standardised rate per 100,000 resident population, ICD-10: C00-C97, D00-D09, D33, D37-D48, 2015/16-2017/18

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (MP), Nov-18

#### Figure 406: Emergency Hospital Admissions: Trend





No significant change compared with a stable trend for Kent

#### Emergency hospital admissions with cancer: trend

Age standardised rate per 100,000 resident population, ICD-10: C00-C97, D00-D09, D33, D37-D48, 2010/11 to 2017/18



No significant change compared with a stable trend for Kent

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (MP), Nov-18



#### Emergency hospital admissions with cancer: trend

Age standardised rate per 100,000 resident population, ICD-10: C00-C97, D00-D09, D33, D37-D48, 2010/11 to 2017/18



No significant change compared with a stable trend for Kent



Emergency hospital admissions with cancer: trend

Age standardised rate per 100,000 resident population, ICD-10: C00-C97, D00-D09, D33, D37-D48, 2010/11 to 2017/18

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (MP), Nov-18

This graph demonstrates a deprivation gap where the most deprived are more likely to admitted to hospital as an emergency when compared to the least deprived. This gap has not seen much change since 2010/2011.





Least deprived trend - stable with a similar pace of change to England Most deprived trend - stable with a similar pace of change to England

#### Figure 411: Emergency hospital admissions with cancer - by ward

# Exercised rate per 100,000 resident population, ICD-10: C0D-070, D0D-D0D, D33, D37-D48, 2015/10-2017/10 Test exercised rate per 100,000 resident population, ICD-10: C0D-070, D0D-D0D, D33, D37-D48, 2015/10-2017/10 (exercised rate per 100,000 resident population, ICD-10: C0D-070, D0D-000, D33, D37-D48, 2015/10-2017/10 (exercised rate per 100,000 resident population, ICD-10: C0D-070, D0D-000, D33, D37-D48, 2015/10-2017/10 (exercised rate per 100,000 resident population, ICD-10: C0D-070, D0D-000, D33, D37-D48, 2015/10-2017/10 (exercised rate per 100,000 resident population, ICD-10: C0D-070, D0D-000, D33, D37-D48, 2015/10-2017/10 (exercised rate per 100,000 resident population, ICD-10: C0D-070, D0D-070, D33, D37-D48, 2015/10-2017/10 (exercised rate per 100,000 resident population, ICD-10: C0D-070, D0D-070, D33, D37-D48, 2015/10-2017/10 (exercised rate per 100,000 resident population, ICD-10: C0D-070, D0D-070, D33, D37-D48, 2015/10-2017/10 (exercised rate per 100,000 resident population, ICD-10: C0D-070, D0D-070, D0D-070, D33, D37-D48, 2015/10-2017/10 (exercised rate per 100,000 resident population, ICD-10: C0D-070, D0D-070, D0D-070,

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (MP), Nov-18

#### Figure 412



#### Emergency hospital admissions with cancer: by electoral ward

Age standardised rate per 100,000 resident population, ICD-10: C00-C97, D00-D09, D33, D37-D48, 2015/16-2017/18

#### Emergency hospital admissions with cancer: by electoral ward

Age standardised rate per 100,000 resident population, ICD-10: C00-C97, D00-D09, D33, D37-D48, 2015/16-2017/18



Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (MP), Nov-18

Figure 414

#### Emergency hospital admissions with cancer: by electoral ward

Age standardised rate per 100,000 resident population, ICD-10: C00-C97, D00-D09, D33, D37-D48, 2015/16-2017/18



#### Conclusion:

Cancer is becoming increasingly prevalent, increasing by around 0.2 - 0.25% per year in East Kent, or around 1,800 more patients annually in the population. Deprivation patterns are different, with the least deprived being shown to have a higher prevalence rate, and the most deprived having higher rates of emergency admissions. This will affect demand on services year on year. People are surviving longer with cancer, which will also alter the type of services people may need.

Cancer will be the theme of Kent County Council's 2019 Annual Public Health Report.

#### **Recommendations:**

To work with Kent and Medway Cancer Collaborative for raising public awareness of signs and symptoms of cancer.

To Improve the case finding for Lung Cancer and improve early diagnosis rates.

To develop initiatives for people to seek help earlier, facilitating earlier diagnosis of cancer in primary care and prompt referral for treatment in secondary care. – particularly those in more deprived areas.

Investigate how demographic changes, particularly an ageing population will change cancer prevalence, including increased survival, that will impact on demand for services.

To embed equity audit in each Cancer pathway starting with Lung and Breast Cancer.

# **10.6 Screening Programmes**

# 10.6.1 Screening – National Programmes

National screening programmes are stipulated in an agreement between the Department of Health and Social Care and NHS England – the Public Health Functions Agreement also known as the "Section 7a Agreement" which is revised annually.

https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2018-to-2019

## https://www.england.nhs.uk/publication/public-health-national-service-specifications/

Locally, NHS England (South East) – this is subject to NHSE reorganisation – has a Public Health Commissioning Team and embedded in this is a Public Health England team, the Kent and Medway Screening and Immunisation Team. This section has largely been produced by this team. The team works with the East Kent CCGs, practices and NHS Providers to improve screening rates and ensure safety and quality standards are met.

The aim of national screening programmes is to improve health by detecting treatable disease early and to promptly refer onwards to treatment services and in some cases prevent disease. A balance has to be struck to ensure that unnecessary or over investigation is minimised whilst not missing many cases. This balance, as well as acceptable costs has to be struck in order for screening programmes to go ahead. A key characteristic is the need for consistently high quality in all stages of a screening programme.

In all programmes the aim is to offer informed choice as to whether to participate or not. There are targets for coverage, or sometimes for uptake, which should be achievable if programme information is of good quality and the programmes are accessible and acceptable.

The East Kent CCGs and the practices within them have a direct and key role in some screening programmes e.g. taking samples for cervical screening. In other programmes there can be strong influence through supporting or endorsing programmes and in individually informing patients about screening programmes.

National Screening Programmes are conventionally grouped and named:

Antenatal and Newborn Screening Programme, which comprises

- Infectious Diseases in Pregnancy
- Sickle and Thalassemia Screening
- Downs and Fetal Anomaly Screening
- Newborn Bloodspot Screening
- Newborn Infant Physical Examination

### **Cancer Screening Programmes**

• Cervical Screening

- Breast Screening
- Bowel Cancer Screening, including Bowel Scope

Adult Screening Programmes (non-cancer)

- Abdominal Aortic Aneurysm Screening
- Diabetic Eye Screening

# **10.6.2 Screening Statistics**

There are many measures in screening programmes, used to indicate how well they are functioning. The majority are technical measures of performance or quality.

Several years ago, key performance indicators were developed, about three for each programme, and these usually provide information on coverage, the speed of the screening process and a key measure to do with referrals for treatment. Most are reported by screening providers quarterly although some indicators are annual. These are published:

# https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2018-to-2019

# 10.6.3 Antenatal and Newborn Screening Programme

The majority of this is offered as part of antenatal and postnatal care, through midwifery and associated services, e.g. ultrasound departments and, for Newborn Infant Physical Examination, paediatrics. Uptake of the screening programmes is good and usually meets standards. Kent, at 98.4% coverage is performing slightly below England, at 98.9% in 2017/18.

# 10.6.4 Cancer Screening Programmes

### 10.6.4.1 Cervical Screening

Cervical screening uptake has been steadily declining in recent years both nationally and in Kent. 2018 district-level coverage figures show Canterbury has the lowest in coverage in East Kent at 71.0% and Ashford highest at 75.2%. Uptake in the under 50's is lower than the over 50's, typically between 2% to 4% lower in the younger age group.

Combined 3-year results for 2015/16 to 2017/18 show coverage varies considerably in different wards in East Kent, with some as high as 82% and low as 68%. Deprivation shows a 6% uptake difference between the most and least deprived quintiles of the population in Kent.

There is a need to make this screening programme more relevant, acceptable and accessible.

### Figure 415: Cervical cancer screening rate – trend


#### Figure 416: Cervical cancer screening rate - by CCG



Cervical cancer screening rate: by CCG

Source: PHE Fingertips, prepared by KPHO (ZC), Mar-19





Least deprived trend - decreasing with a similar pace of change to England Most deprived trend - decreasing with a similar pace of change to England

Source: PHE Fingertips, prepared by KPHO (ZC), Mar-19

## 10.6.4.2 Breast Screening

As with cervical cancer screening, coverage of breast cancer screening is falling both nationally and locally. 2018 district level data shows Thanet has the lowest recorded rate for East Kent at 74.9%, and Canterbury a high of 78.4%, both lower than the achievable threshold target of 80%, but above the acceptable 70% target.

Combined 3-year results for 2015/16 to 2017/18 show coverage varies considerably in different wards in East Kent, with some as high as 80% and low as 69%. Deprivation shows a 4.9% uptake difference between the most and least deprived quintiles of the population in Kent.





A major influence on uptake is the proximity to women and the accessibility of the mobile screening units. In West Kent there has been some difficulty in the use of the Angel Centre in Tonbridge. There is a clear need to support effective siting of mobile mammography units.

#### Figure 419: Breast cancer screening rate - by CCG



#### Breast cancer screening rate: by CCG

Source: PHE Fingertips, prepared by KPHO (ZC), Mar-19

#### Figure 420: Breast cancer screening rate – by deprivation



Least deprived trend - stable with a similar pace of change to England Most deprived trend - stable with a similar pace of change to England

Source: PHE Fingertips, prepared by KPHO (ZC), Mar-19

## 10.6.4.3 Bowel Cancer Screening, including Bowel Scope

There are currently two screening schemes available. The first is offered every 2 years to men and women aged 60-74. People older than this can ask for a screening kit. Individuals with an abnormal screening result are offered a colonoscopy. The second is a one-off test called bowel scope screening and is being introduced in England for men and women at the age of 55.

2018 district level data for those aged 60-74 screed in the past 30 months shows Thanet CCG has the lowest recorded rate for East Kent at 58.5%, and Ashford CCG a high of 61.2%, all above the minimum target of 52%, but hovering around the 60% achievable target. Screening rates vary more by ward, with the lowest around 52% and highest at 66%. Deprivation also shows large differences, with the most deprived quintile of the population showing coverage of around 9% lower than the least deprived.



## Figure 421

Though invitations for screening do not come from general practice, practices have been shown to able to influence uptake significantly by promoting this programme or through endorsement of invitations. West Kent CCG has a scheme to encourage practices to contact "non-responders".

## Figure 422: Bowel cancer screening rate – by CCG



#### Bowel cancer screening rate (60-74): by CCG

Source: PHE Fingertips, prepared by KPHO (ZC), Mar-19

#### Figure 423: Bowel cancer screening rate – by deprivation



Least deprived trend - increasing with a similar pace of change to England Most deprived trend - increasing with a similar pace of change to England

Source: PHE Fingertips, prepared by KPHO (ZC), Mar-19

Bowel Scope, which comprises and invitation for sigmoidoscopy at age 55 years has been in place in West Kent for several years – West Kent was the first area in England to implement

this programme at scale (it is still not available for many areas e.g. most of Dartford, Medway and East Kent). Uptake is about 50%.

A current problem with Bowel Cancer Screening in West Kent is that there is no more endoscopy capacity – which is required for screening as a new test is being introduced that will lead to a greater demand for colonoscopy. There are several options being explored, including how other services use endoscopy.

## 10.6.5 Aortic Aneurysm Screening Programme

Coverage for Kent in 2017/18 is 81.6% and varies little from year to year. Within that, the East Kent district are all similar to Kent, and Dover and Folkestone & Hythe are higher. These figures compare favourably with England. Access is very good, with many clinic sites available across West Kent.

## 10.6.6 Diabetic Eye Screening Programme

Uptake is generally good, 81.8% for Kent and Medway is the last published figure for Oct-Dec 2018. The KPI for 80% of referrals for proliferative diabetic retinopathy to receive consultation within 4 weeks was not met, with 72.1% in 2017/18 and 68.9% in 2016/17. This programme had been gradually changing – from a van-based service to fewer, static locations though compared to services in other parts of England still provides relatively local access. The change improves efficiency and reliability of equipment.

## **10.7 Immunisations**

## 10.7.1 Immunisation – National Programmes

National immunisation programmes are stipulated in an agreement between the Department of Health and Social Care and NHS England – the Public Health Functions Agreement also known as the "Section 7a Agreement" which is revised annually.

https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2018-to-2019

## https://www.england.nhs.uk/publication/public-health-national-service-specifications/

Locally, NHS England (South East) – this is subject to NHSE reorganisation – has a Public Health Commissioning Team and embedded in this is a Public Health England team, the Kent and Medway Screening and Immunisation Team. This section has largely been produced by this team. The team works with East Kent CCG, practices and NHS Providers to improve immunisation rates.

The aim of national immunisation programmes is in general to provide herd immunity and most immunisations have a target of 95% population coverage or uptake (usually used interchangeably in immunisation) There are exceptions, where the vaccination does not provide herd immunity, i.e. prenatal pertussis and shingles, where the protection is for that individual.

The complete national immunisation schedule is found here:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment data/file/741543/Complete immunisation schedule sept2018.pdf

It may be grouped:

Childhood Immunisation Programme:

- Diphtheria, Tetanus
- Pertussis (whooping cough)
- Polio and Haemophilus Influenzae type b (Hib) (DTaP/IPV/Hib/HepB)
- Pneumococcal (PCV)
- Rotavirus
- Measles, Mumps and Rubella (MMR)
- Hib/MenC
- Pre-school booster (DTaP/IPV) and Meningococcal B (MenB)
- Childhood Seasonal Influenza

School Based Immunisation Programme:

- Human Papillomavirus (HPV)
- Diphtheria, Tetanus
- Polio teenage booster (Td/IPV)
- Meningococcal ACWY

Seasonal Influenza for school years

Adult Immunisation Programme:

- Seasonal Influenza
- Pneumococcal (PPV)
- Shingles

Immunisations for those at risk:

- Neonatal Hepatitis B
- Neonatal BCG (TB)
- Prenatal Pertussis
- Seasonal Influenza

## **10.7.2** Immunisation Statistics

Uptake figures are available from three main sources. All start from general practice.

- 1. ImmForm is a system that collates immunisation summary statistics though usually monthly electronic extracts of general practice data performed by general practice system suppliers' i.e. EMIS etc. Published data is available by CCG but not by individual practice.
- 2. COVER is a quarterly publication of childhood immunisation data supplied in summary form from Child Health Information Systems (CHIS), which in turn rely on individual patient immunisation information from general practices (not always reliable in Kent). COVER produces summary statistics by Local Authority area (Upper Tier, so at the level of Kent County Council). Data is not available by CCG or individual practice.
- 3. NHS Digital publish childhood immunisation statistics by CCG/STP/GP Practice level<sup>35</sup>. The source for this was an electronic extraction from CHIS databases. The data is viewable as tables and also through an interactive Power BI platform.

Immunisation statistics can vary considerably over time, therefore it is important to try to base assessments and actions on up to date information.

The Screening and Immunisation Team provide a 30 page Statistical Report which provides a commentary on collated data from a variety of sources. It is regularly refreshed.

The latest version is enclosed – click on the icon:



One particular area of concern is measles infection. Between 1 January 2018 and 31 October 2018, there have been 913 laboratory-confirmed measles cases in England. This steep rise in cases (when compared to 259 lab-confirmed measles cases in 2017), was associated with outbreaks linked to importations from Europe that have led to some limited spread in the community, particularly teenagers and young adults who missed out on their MMR vaccine when they were younger. To try and counter this, Public Health England have produced a 'UK Measles and Rubella elimination strategy 2019'<sup>36</sup>. The four aims of this are:

- 1. Achieve and sustain  $\geq$  95% coverage in the routine childhood programme.
- 2. Achieve  $\geq$  95% coverage with 2 doses of MMR vaccine in older age cohorts through opportunistic and targeted catch-up.
- 3. Strengthen measles and rubella surveillance.
- 4. Ensure easy access to high-quality, evidence-based information.

<sup>&</sup>lt;sup>35</sup> https://digital.nhs.uk/data-and-information/publications/statistical/childhood-immunisation-ccg-gppractice-level-coverage-statistics/childhood-vaccination-statistics-ccg-gp-practice-level-coverage-2017-18m.i/childhood-vaccination-statistics-ccg-gp-practice-level-coverage-2017-18-m.i#resources

<sup>&</sup>lt;sup>36</sup> https://www.gov.uk/government/publications/measles-and-rubella-elimination-uk-strategy

## Figure 424: Measles vaccination coverage by CCG



## **10.8 Mental Health**

Please refer to Kent and Medway's raft of Mental Health Needs Assessments:

https://www.kpho.org.uk/\_\_data/assets/pdf\_file/0019/101854/Mental-Health-NA-Kent-2019.pdf

The relevant needs assessments for East Kent will be found on the Kent Public Health Observatory and ensure there are is link to the recommendations there.

People with mental illness experience higher rates of morbidity and have a lower life expectancy then those without mental illness. Individuals with chronic physical health problems are also more likely to experience mental health problems: currently 30% of patients with a long-term condition have a mental health problem (Source: Kent Integrated Dataset).

## A Note on Mental Health and Mental Illness

Like physical health – mental health ranges between those with good mental health who may suffer bouts of illness and then recover with help and support – right through to those with serious and long-term mental illness who will require lifetime of support and care. All mental illness is dynamic in nature and people can move quickly from needing acute care to being relatively stable in the community. Mental illness has traditionally been stigmatised and people are often reluctant to get help and may feel ill equipped to ask for help. Services needed to be responsive, trauma informed and agile to understand the needs of people in distress. All mental illness has a social and genetic component. All mental illness is defined by a series of signs and symptoms. For many conditions there is help available- however many mental health services have been traditionally re-organised, not joined up, given thresholds of care that do not take into account a person's holistic needs and difficult for many to access. Many of these issues will now need to be addressed by the whole health and social care system. In addition, it is important to tackle the health care of those with serious and enduring mental health problems as they die 20 years earlier than those with no mental illness.

## The Services on offer:

For people suffering mild or moderate mental health problems the first step is self care.

Primary care can advise on self care and much help and information is available via national and local websites. There are also on line, text and support phone lines available for support.

For those who are suffering persistent (over 14 days) of mental distress or who feel in crisis – seek help from primary care.

For those who feel they need psychological therapy – they can access this free on the NHS

For those who are suffering more severe and enduring symptoms where primary care has not been able to help – a referral can be made to specialist psychiatric and psychological services. These are provided in Kent – by KMPT.

For those in acute distress who feel unsafe – there is a crisis care help line and crisis team number. For a small number of people it may be necessary to arrange a hospital admission for assessment and medication and a proactive care plan to be formulated.

## **Recommendations:**

- Create Local Place Based Partnership Plans to tackle health inequalities and wellbeing in the areas of greatest vulnerability.
- Create a whole system approach to 'social prescribing' and connecting people to the assets and networks that exist in their communities to enhance wellbeing.
- Commission services that are Adverse Childhood Experiences aware and workers are trained to understand the underlying issues as part of their work. Commissioners and providers will need to ensure training and supervision are core to delivery.
- Tackle the issue of social isolation in people of all ages in Kent. Use the combined assets and commissioning resources across the public sector to increase opportunities to reduce social isolation in the vulnerable population in Kent.
- Ensure that there is equity and ease of access for NHS Psychological Services
- Ensure that there is high quality joined up care for those needing community mental health services ensure this care is joined up between primary and specialist services with flexible and agile care co-ordination in place for vulnerable people.
- Ensure the health of people on the SMI register is tackled proactively.
- Ensure no barriers for care, treatment and support exist for those with co-occurring conditions (substance misuse and mental illness).
- Tackle the increasing prevalence in severe depression by ensuring care and support is joined up including good patient awareness of the pathway.

- Ensure that there are high quality and accessible information available to people in distress.
- Ensure all services are Trauma Informed and able and equipped to deal with a person's distress
- Promote wellbeing via six ways to wellbeing or similar
- Focus on Thanet and ensure the population of Thanet have high quality and accessible mental health services and a well supported voluntary and community sector.
- Understand better the interventions for crisis care and how these can be linked to a person's on going treatment options in order to prevent the second crisis.
- Work across all systems to share different agencies learning from serious incidents and near misses so the system can mature and learn.
- Ensure there is good quality patient advocacy in place.

## **Definitions of Mental illness**

There are two main categories of mental illness referred to as 'common mental illness' such as depression and anxiety, and 'severe and enduring mental illness' such as schizophrenia (psychosis) and bi-polar disorder. The APMS presents prevalence estimates by region for common mild to severe mental health disorders. The table below presents modelled estimates based on these prevalences for the East Kent GP registered population as at March 2019. As they are survey-based estimates, the true numbers are likely to deviate from this. Confidence ranges were not given, and as East Kent is generally more deprived than the South East, some of the numbers given below may be an underestimate.

Mental health Condition	Prevalence - Male	Prevalence - Female	Male Estimate	Female Estimate	Total East Kent Esitmate	
Common Mental Disorders - Self rep	orted episode within past week (		Age standardised rate for SE England)			
Generalised anxiety disorder	4.1%	6.7%	11,856	20,388	32,244	
Depressive episode	2.3%	2.5%	6,651	7,608	14,258	
Phobias	1.6%	2.4%	4,627	7,303	11,930	
Obsessive compulsive disorder	0.5%	0.7%	1,446	2,130	3,576	
Panic disorder	0.2%	0.3%	578	913	1,491	
Other common mental disorder	3.1%	7.7%	8,964	23,431	32,395	
Psycotic disorder within last year	0.1%	0.8%	289	2,434	2,724	
Adult Autism (ASR for South England)	2.4%	0.4%	6,940	1,217	8,157	
Antisocial personality disorder, (ASPD), positive screen	6.1%	0.8%	17,639	2,434	20,073	
Borderline Personality Disorder (BPD), positive screen	2.7%	1.8%	7,807	5,477	13,285	
Attention Deficit Hyperactive Disorder (ADHD), age standardised positive screen for SE England	9.1%	8.4%	26,313	25,561	51,875	
Bi polar disorder, age standardised positive screen	1.8%	1.5%	5,205	4,565	9,769	
Alcohol dependence, probable high dependance, (ASR for SE England)	1.9%	0.2%	5,494	609	6,103	
Hazardous or harmful drinking	25.9%	13.6%	74,892	41,385	116,277	
Drug dependence (any drug)	2.8%	1.8%	8,096	5,477	13,574	
Trauma experienced in lifetime	34.5%	29.9%	99,760	90,986	190,746	
PTSD diagnosed	3.1%	3.6%	8,964	10,955	19,919	

## Table 22: Modelled estimates of mental health conditions for East Kent adults age 16+

The 2014 Adult Psychiatric Morbidity Survey (APMS)<sup>37</sup>, the most recent major survey on mental health, highlights higher rates of common mental health problems being found among younger women (aged 16 to 24 years) compared to their male peers. In 1993, young women of this age group were twice as likely to have symptoms of a common mental health problem - at 19.2% - compared to young men - at 8.4%. This increased by 2014, where these symptoms are nearly three times more common in young women (26.0%) than men (9.1%). The findings also show that nearly 25% of young women in this age group have self-harmed in their life. These stark patterns indicate the need for the STP to support the development of effective strategies for preventing common mental health problems in women. It is likely that these strategies will need to take into consideration that men are known to be under represented in diagnosis of common mental illness, but, there are a combination of a range of factors which women are more vulnerable to experiencing in their life time (such as domestic violence, physical and sexual abuse) which interact with one another.

## 10.8.1 Recorded Prevalence of Serious Mental Health Conditions

Recorded prevalence of serious mental health conditions is above the Kent average in Canterbury & Coastal CCG, South Kent Coast CCG and Thanet CCG, and below Kent in Ashford CCG.

<sup>&</sup>lt;sup>37</sup> <u>https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey</u>

There is a clear deprivation gradient with patients in the most deprived quintile approximately 30% more likely to have a serious mental health condition than the least deprived. The rate of increase of diagnosis is roughly double in the most deprived population with calculations from 2013-14 to 2017-18 showing a 0.031% prevalence increase per year compared to 0.014% increase in the least deprived in Kent.

There are variations of recorded prevalence based on geographic locations. The following wards are significantly higher than their parent CCG:

## Ashford CCG:

• Stour

Canterbury & Coastal CCG:

- Northgate
- Sturry North
- Sturry South
- Barton
- Wincheap
- Marshside
- Westgate

South Kent Coast CCG:

- Folkestone Harvey Central
- Folkestone East
- Folkestone Foord
- Folkestone Harvey West
- Folkestone Harbour

## Thanet CCG

- Westbrook
- Cliftonville West
- Garlinge
- Dane Valley



#### Figure 425: Recorded prevalence of serious mental health conditions - by CCG

Recorded prevalence of serious mental health conditions: by CCG

Source: QOF, prepared by KPHO (RK), Jan-19

## Figure 426: Recorded prevalence of serious mental health conditions – deprivation



Recorded prevalence of serious mental health conditions: by deprivation

The percentage of patients recorded on GP QOF registers as having schizophrenia, bipolar affective disorder, other psychoses or on lithium

Least deprived trend - increasing with a similar pace of change to England Most deprived trend - increasing with a similar pace of change to England

Source: QOF, prepared by KPHO (MP), Nov-18

## Figure 427: Recorded prevalence of serious mental health conditions - by ward

#### Recorded prevalence of serious mental health conditions: by electoral ward

The percentage of patients recorded on GP QOF registers as having schizophrenia, bipolar affective disorder, other psychoses or on lithium therapy, modelled ward-level estimates, 2015/16-2017/18



#### Figure 428



#### Recorded prevalence of serious mental health conditions: by electoral ward

#### Figure 429



#### Figure 430



#### Recorded prevalence of serious mental health conditions: by electoral ward

## 10.8.2 Recorded Prevalence of Depression Age 18+

The recorded prevalence of depression is above the Kent average in Ashford, Canterbury & Coastal and Thanet CCGs, and similar to Kent in South Kent Coast CCG. All four CCGs are above the recorded England prevalence of 9.9% for 2017/18.

Anxiety is not currently recorded as a QoF measure; however, it is well recorded in general practice. An evaluation of primary care data in the Kent Integrated Dataset (KID) showed 9.1% of the population from flowing practices were recorded as currently having anxiety.

There is a significant increasing trend in diagnosed depression in adults age 18+, which in 2017/18 was over 10% for Kent, and has been increasing at a rate of more than 1% prevalence per year from 2013/14 to 2017/18. There is also a moderate deprivation difference, with approximately 13% more diagnosed in the most deprived quintile of the population compared to the least deprived. The rate of change has been larger in the most deprived, with a 1.1% annual prevalence increase in the most deprived compared to 0.8% in the least.

There are variations of recorded prevalence based on geographic locations. The following wards are significantly higher than their parent CCG:

## Ashford CCG:

- Park Farm North
- Park Farm South
- Washford
- Charing
- Norman
- Beaver
- Stanhope
- Weald East
- Downs West
- Victoria

## Canterbury & Coastal CCG:

- Herne & broomfield
- East Downs
- Heron
- Abbey
- Greenhill & Eddington
- Davington Priory
- West Bay

- Boughton & Courtenay
- St Ann's
- Watling

## South Kent Coast CCG:

- North Downs East
- Lympne and Stanford
- New Romney Town
- Romney Marsh
- Folkstone Foord
- Tolsford
- Castle
- Town & Pier
- Folkestone Harvey West
- Elham & Stelling Minis
- Folkestone East
- Folkestone Park

## Thanet CCG

- Newington
- Garlinge

- Margate Central
- Northwood
- Eastcliff
- Westbrook
- Sir Moses Montefiore

- Central Harbour
- Cliffsend & Pegwell
- Kingsgate
- Thanet Villages

## Figure 431: Recorded prevalence of depression – by CCG



Recorded prevalence of depression: by CCG

Percentage of patients (aged 18+) recorded on QOF GP registers as having depression, 2017/18

Source: QOF, prepared by KPHO (RK), Jan-19





Recorded prevalence of depression: by deprivation

Least deprived trend - increasing with a similar pace of change to England Most deprived trend - increasing with a similar pace of change to England

Source: QOF, prepared by KPHO (MP), Nov-18

#### Figure 433: Recorded prevalence of depression - by ward



## Recorded prevalence of depression: by electoral ward

#### Figure 434



#### Figure 435



## Recorded prevalence of depression: by electoral ward

Health needs assessment: East Kent, August 2020

#### Figure 436



## 10.8.3 Emergency Hospital Admissions for Mental Health Conditions

The rate of emergency admissions to hospital for mental health conditions in Canterbury & Coastal CCG and Thanet CCG is above the Kent average, similar to the average in South Kent Coast CCG and below Kent in Ashford CCG

Overall in Kent, hospital admissions for mental health conditions have been decreasing and have been doing so at a faster rate than England. The rate of reduction varied, with the most deprived quintile of the population reducing admissions by 23% between 2011/12 – 2012/13 and 2015/16 – 2017/18, compared to a 19.6% reduction in the least deprived.

There is significant variation across wards, with the following having significantly higher emergency hospital admission rates than the Kent average.

## Ashford CCG

- Bybrook
- Victoria
- Aylesford Green

## Canterbury & Coastal CCG

- Northgate
- Heron

- Sturry North
- Wincheap
- St Stephens
- Westgate
- Barton
- Davington Priory
- Abbey
- West Bay

- Harbour
- Seasalter

South Kent Coast CCG

- Folkestone Harbour
- Folkestone Harvey Central
- Castle
- Folkestone Foord
- Folkestone Harvey West
- Middle Deal & Sholden

• Tower Hamlets

## Thanet CCG

- Cliftonville West
- Margate Central
- Central Harbour
- Westbrook
- Eastcliffe
- Westgate-on-sea
- Northwood

## Figure 437: Hospital admissions for mental health conditions – by CCG (of residence)

Hospital admissions for mental health conditions: by CCG Age standardised rate per 100,000 resident population, ICD 10: F (primary diagnosis), 2013/14-2017/18



Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (ZC), Nov-18

#### Figure 438: Hospital admissions for mental health conditions - trend



Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (ZC), Nov-18

## Figure 439: Hospital admissions for mental health conditions – deprivation



Hospital admissions for mental health conditions: by deprivation Age standardised rate per 100,000 resident population, ICD 10: F (primary diagnosis), 2010/11-2014/15 to 2013/14-2017/18

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (ZC), Nov-18

## Figure 440: Hospital admissions for mental health conditions - by ward



#### Figure 441



## Hospital admissions for mental health conditions: by electoral ward

Age standardised rate per 100,000 resident population, ICD 10: F (primary diagnosis), 2013/14-2017/18

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#### Figure 442

#### Hospital admissions for mental health conditions: by electoral ward

Age standardised rate per 100,000 resident population, ICD 10: F (primary diagnosis), 2013/14-2017/18



#### Figure 443



## Hospital admissions for mental health conditions: by electoral ward

Age standardised rate per 100,000 resident population, ICD 10: F (primary diagnosis) , 2013/14-2017/18

## 10.8.4 Suicides and Self-Harm

Suicide is the leading cause of death in males under the age of 45 in England and is approximately 3 times more likely to occur amongst males than females. Suicide rates in Kent and England have broadly remained unchanged over the past 5 years, however individual CCGs have shown fluctuations in rates. Efforts are continuing to combat the serious issue as the consequences for families and loved ones of victims are severe.

The table below presents the counts and rates for the last two time periods we have data for. Kent as a whole is slightly higher than the England rate of 14.7 per 100,000. Thanet CCG has a statistically higher suicide rate in both males and females than England for both 2014-16 and 2015-17, and South Kent Coast CCG had a significantly higher rate for females in 2015-17.

Suicides in East Kent	Year	Male - Count	Male - Rate per 100,000	Female - Count	Female - Rate per 100,000
Kent	2014 - 16	352	18.4	109	5.3
	2015 - 17	309	15.9	115	5.5
Ashford CCG	2014 - 16	29	19.1	Supressed	Supressed
	2015 - 17	23	14.7	Supressed	Supressed
Canterbury & Coastal CCG	2014 - 16	40	15.3	12	4.4
	2015 - 17	46	16.2	17	6.1
South Kent Coast CCG	2014 - 16	54	19.7	15	5.6
	2015 - 17	42	15.1	21	7.9
Thanet CCG	2014 - 16	40	24.0	18	9.4
	2015 - 17	37	22.0	18	9.1

## Table 23 – Suicide counts and rates for East Kent CCGs, 2014-16 to 2015-17, age 10+

Source: PHE Fingertips

#### Figure 444



Deprivation has been demonstrated to be a key factor in risk of suicide. The figures below demonstrate a clear deprivation gradient, and that those in the lowest decile for deprivation in Kent are significantly more likely to be a victim. The longer-term trend has shown that this has been a persistent issue, and between 2011-13 to 2015-17 there has been more than double the suicide rate in the most deprived decile than the least.

## Figure 445: Mortality from Suicide by deprivation in Kent: 2015-17



Source: Primary Care Mortality Database; Office for National Statistics, KPHO (JB)

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## Figure 446: Mortality from Suicide by deprivation in Kent: Trend



Suicide rates vary greatly with age and gender. Males are considerably more likely to commit suicide than females across most age bands apart from in older age groups. For both males and females, suicide is most common in the 45 to 55 age band, followed by ages 35-44 and 55-64. The prevalence in males under 35 remains at high levels but lowers significantly for females.



#### Figure 447: Numbers of death from suicide by age band and gender, 2014/15 to 2017/18

## 10.8.4.1 Hospital Admissions for Self-Harm

The rate of emergency admissions to hospital for self-harm amongst young people is around the Kent average across all four East Kent CCGs, although South Kent Coast appears to have the highest rate. Overall, there is a stable or slight decreasing trend across Kent and the East Kent CCGs, although the section below highlights particular groups where this is not the case.

There is a significant gap between young people living in the most and least deprived parts of Kent. Although the size of this gap is decreasing due to reducing admission rates in the most deprived areas there is still more than double the rate of admissions in the most deprived than the least deprived quintiles of the population.

It is estimated that 22% of 15-year olds have ever self-harmed, 32% of young women and 11% of young men. Emergency admissions and presentations to acute care for self-harm are therefore not reflective of the estimated prevalence of the behaviour in the population. <sup>38</sup>



Figure 448: Emergency hospital admissions for self-harm in young people – by CCG

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Nov-18

<sup>&</sup>lt;sup>38</sup> https://sites.manchester.ac.uk/ncish/

## KENT PUBLIC HEALTH

#### Figure 449: Emergency hospital admissions for self-harm in young people – trend



No significant change compared with a stable trend for Kent

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Nov-18

#### Figure 450



Age standardised rate per 100,000 resident population, ICD 10: X60-X84 (main recorded cause), 2010/11 to 2017/18



No significant change compared with a stable trend for Kent

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Nov-18

## Figure 451

#### Emergency hospital admissions for self-harm: trend

Age standardised rate per 100,000 resident population, ICD 10: X60-X84 (main recorded cause), 2010/11 to 2017/18



Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Nov-18

No significant change compared with a stable trend for Kent





Decreasing compared with a stable trend for Kent

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Nov-18

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## Figure 453: Emergency hospital admissions for self-harm in young people – by deprivation



Emergency hospital admissions for self-harm: by deprivation

Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Nov-18

Rates of admissions for self-harm are higher for females than males and are highest in the 17-20 age group across Kent. There is some evidence to suggest that rates of admissions since 2010-11 are increasing faster in females and at the greatest rate of increase in females age 17-20, with 13-16-year-old females also increasing. For male adolescents, the rate is highest in the 13-16 age group, but rates have been falling in the older 17-20 age group.



Figure 454: Admissions for self-harm by age, Males and Females, Kent & Medway



Figure 455: Admissions for self-harm by age, Females, Kent & Medway

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Rate per 10,000 Male & Female	2010- 11	2011- 12	2012- 13	2013- 14	2014- 15	2015- 16	2016- 17	2017- 18
Age 13-16	38.6	36.5	33.8	49.1	57.9	47.3	43.1	43.6
Age 17-20	51.7	44.8	40.6	47.1	41.6	54.9	36.9	35.7
Age 10-24	39.8	35.3	32.3	39.5	39.0	42.8	31.6	30.7
_								
Rate per 10,000 Females	2010- 11	2011- 12	2012- 13	2013- 14	2014- 15	2015- 16	2016- 17	2017- 18
Rate per 10,000 Females Age 13-16	2010- 11 66.9	2011- 12 63.8	2012- 13 61.5	2013- 14 89.6	2014- 15 102.9	2015- 16 78.3	2016- 17 70.2	2017- 18 73.4
Rate per 10,000 Females Age 13-16 Age 17-20	2010- 11 66.9 76.5	2011- 12 63.8 72.9	2012- 13 61.5 61.8	2013- 14 89.6 63.7	2014- 15 102.9 82.7	2015- 16 78.3 115.1	2016- 17 70.2 76.8	2017- 18 73.4 81.2

## Table 24 Admissions for self-harm by age group and gender, Kent & Medway: Data tables





## 10.8.5 Child and Adolescent Mental Health (CAMHS)

Enjoying mental health wellbeing is central to the overall development of children and young people. Mental health problems in children are associated with educational failure, family disruption, disability, offending and antisocial behaviour, placing demands on social services, schools and the youth justice system.
The children and young people's mental health system is subject to significant strategic policy focus. In Kent, this has included the Kent 'The Way Ahead'<sup>39</sup> and the Kent Transformation Plan for Children, Young People and Young Adult's Mental Health Provision<sup>40</sup> which is takes forward the targets of the 'NHSE Five Year Forward for Mental Health'<sup>41</sup>. The Kent Transformation Plan includes an ambition to increase research and resilience, early help and prevention, specialist and crisis services. Meeting the national access target for evidence-based community services is balanced with a need to increase early intervention and promote emotional and mental wellbeing.

#### 10.8.5.1 Incidence and prevalence of Child and Adolescent mental health

It is estimated that 50% of lifetime mental illness (except dementia) begins by the age of 14<sup>42</sup> and 75% by age 24<sup>43</sup>. The enduring nature of and deterioration of mental health disorders which start in childhood mean that intervening with children is critical for preventing adult mental health as well as the poorer life chances that result from mental ill health in childhood which have a cumulative impact into adulthood. The current best estimates of the prevalence of mental illness in children and young people suggests that 12.8% of children aged 5 to 19 years have a diagnosable mental health condition<sup>44</sup>. These prevalence estimates date from research conducted in 2017. This is a slight increase in prevalence from 2004, which is being driven by an increase in emotional health conditions. The prevalence of mental health conditions increases with age, with higher prevalence amongst young people aged 17-19.

#### 10.8.5.2 CAMHS Services

Across Kent and Medway, NELFT provide specialist Mental Health Services for children and young people (CYP) alongside KMPT for Early Intervention Psychosis services.

In Kent, NELFT collaborate with KCHFT to deliver a single point of access for children and young people's mental health conditions. KCHFT provide advice and information on emotional and behavioural health conditions as well as access to structured one to one intervention for CYP with mild to moderate mental health needs.

Addaction's Mind and Body Programme provides an early intervention self-harm programme in secondary schools across Kent. The Mind and Body programme consists of

<sup>&</sup>lt;sup>39</sup> https://www.kent.gov.uk/\_\_data/assets/pdf\_file/0003/46821/Emotional-Wellbeing-Strategy-part-1-strategic-framework.pdf

<sup>&</sup>lt;sup>40</sup> https://www.kent.gov.uk/about-the-council/strategies-and-policies/health-policies/transforming-healthand-social-care-in-kent-and-medway

 <sup>&</sup>lt;sup>41</sup> https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
<sup>42</sup> Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Bedrihan Urstun T (2007). Age of onset of mental disorders: a review of recent literature. Current Opinion in Psychiatry 20(4): 359-364.

<sup>&</sup>lt;sup>43</sup> Kessler R, Berglund P, demler o et al. (2005) lifetime prevalence and age-of-onset distributions of dsM-lv disorders in the national comorbidity survey Replication. Archives of General Psychiatry 62: 593–602.

<sup>&</sup>lt;sup>44</sup> https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

an assembly regarding risk taking behaviours, a preliminary baseline assessment to screen for individuals at high risk of self-harming, eight group sessions and three one-to-one sessions with a practitioner for needs-based support.

KCHFT are commissioned by Kent County Council to provide the School Public Health Service to primary and secondary school children, including tier 1 and 2 interventions. Targeted mental health services offer support and treatment for mild to moderate emotional wellbeing and mental health problems of CYP.

In 2018/19 Kent CCGs commissioned <u>The BeYou Project</u>, provided by Porchlight in order to support LGBTQ CYP. The LGBTQ support service has a website and youth groups set up for CYP in the LGBTQ community and aims to raise awareness in their local area, connect young LGBTQ people and provide a safe, welcoming, non-judgemental space with support, mentorship and advice.

In addition, Porchlight provide the Porchlight Adolescent Wellbeing Service in Thanet CCG in partnership with NELFT. Services provided include stress buster classes, parenting programmes and 'listen to me, listen to you' which helps families develop better methods of communicating with each other.

<u>Good Mental Health Matters</u> is an NHS initiated resource that empowers young people, in school years 6 to 13, by encouraging them to take personal responsibility for their own wellbeing. It offers simple, positive strategies and advice that can be accessed by teachers and professionals, parents and young people through their schools to promote good mental health.

<u>Fantastic FRED</u> will be delivered in primary schools across Kent over the next two years. FRED is an acronym for the four practical ways in which children can help to look after their own good mental health:

- Food eating the right foods
- Rest getting enough sleep
- Exercise being active
- Digital Devices managing time online.

<u>Headstart</u> Kent is a big lottery funded programme which is part of Kent County Council's Early Help and Preventative Services. It is a research and development programme which aims to build resilience in 10-16-year olds preventing them from experiencing common mental health problems. Headstart Kent's programme takes a universal and targeted approach. It includes the development of a Resilience Hub which provides access to resources for children and young people, parents and carers and professionals and includes a toolkit for whole school health improvement, access to training on Resilience focussed conversations with young people. HeadStart Kent's targeted offer includes mentoring, online counselling 'KOOTH'.

#### Access to services:

Children and Young People's access to Mental Health Services is monitored by NHS England through the <u>Mental Health Services Dataset</u>. The Five Year Forward View aims to ensure that 35% of the estimated diagnosable mental health need is met by evidence-based interventions in community settings by 2020/21, with annual incremental access targets. Performance data for 2018/19 (target 32%) evidenced that all East Kent CCGs will met and exceed the target. While East Kent CCGs will exceed the target, there are still high levels of unmet need. The NHS Long Term Plan outlines the ambition to ensure that 100% of CYP who need specialist MH care when they need it can access it within the decade<sup>45</sup>. There are known limitations associated with this dataset, including the methodology of calculating access.

#### Services outcomes:

From April 2020, CCGs and providers will be monitored by NHS England regarding outcomes from Mental Health services and work is currently happening to establish an outcomes metric which could be implemented universally across services. Currently, providers collate their own outcomes measures based on reliable and valid measures suitable for the cohort of young people they work with.

#### NELFT

NELFT are currently piloting outcomes metrics in line with the anticipated NHS England outcomes metric.

#### Mind and Body (Addaction)

A review of Mind and Body's early intervention self-harm programme has recently been conducted by Addaction and the University of Bath<sup>46</sup>. Overall, the Mind and Body programme resulted in an efficient identification, referral and support for young people engaging in self-harm and/or risk-taking behaviour. Mind and Body had a positive impact on young peoples' awareness, thoughts, feelings, behaviours relating to self-harm and risk-taking and on their overall well-being.

Between July 2018 and February 2019 in the East Kent CCGs, 1,651 CYP aged 13 to 17 years received information and advice about self-harm and risk-taking behaviours (517 in Ashford, 369 in Canterbury & Coastal, 472 in South Kent Coast and 293 in Thanet); 115 CYP completed the Mind and Body programme<sup>47</sup> within this time period (15 in Ashford, 38 in Canterbury & Coastal, 28 in South Kent Coast and 34 in Thanet). Across Kent, compared to their pre-intervention interviews, the following outlines the findings from the survey:

<sup>&</sup>lt;sup>45</sup> https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

https://www.addaction.org.uk/sites/default/files/public/attachments/mind\_and\_body\_impact\_report\_2017.p df

<sup>&</sup>lt;sup>47</sup> Source: Mind and Body, March 2019

- Of the 285 CYP that participated in Mind and Body programme, 79.3% of CYP reported an overall improvement in their mental wellbeing following participation (target 70%).
- Around 87% of participants reported a reduction in number of days in which they thought about self-harming, 27% points above the 60% target (n =146),
- 93.7% (target 70%, n=259) of participants reported they were better able to manage risks relating to self-harm following participation

#### KCHFT

For those who finished the service between January and March 2018 across Kent, 41% of CYP reported their problems had changed in a 'much better' direction and 44% reported they were 'a bit better'. Nearly a third (29%) said the intervention had been 'a great deal' helpful in other ways, and a further 44% reported that the intervention had been 'a medium amount' helpful in other ways<sup>48</sup>.

#### The BeYou project

Qualitative data from CYP accessing the BeYou service suggests positive benefits from the BeYou service, for example:

'I feel comfortable and accepted at this group and am always excited to attend. I look forward to giving updates on my life as I know that all will be supportive. It is a good service. You have my applause.'

CYP were asked on a scale of 1 to 6 (with 6 being highest) 'Do you feel that there has been an improvement to your emotional wellbeing as a result of accessing a BeYou group/mentoring?'. The average response across participants was 5<sup>49</sup>.

#### Headstart

Data from the Wellbeing Measurement Framework 2018<sup>50</sup> demonstrated that:

- Areas of strength were goal setting, empathy, family support and peer support.
- Younger students had a slightly better appraisal of their wellbeing and reported slightly less difficulties than older students.
- Males reported more difficulties in relation to behaviour, attention and peers.
- Females reported more emotional difficulties and had a less positive appraisal of their wellbeing.
- Students eligible for Free School Meals or with Special Education Needs reported more difficulties and had a less positive appraisal of their wellbeing.
- A large proportion of students had a high level of attention difficulties. However, younger students reported the same level of attention difficulties compared to last year and older students slightly less attention difficulties, suggesting an improvement.

<sup>&</sup>lt;sup>48</sup> Source: KCHFT, 2018

<sup>&</sup>lt;sup>49</sup> Source: Porchlight 2019

<sup>&</sup>lt;sup>50</sup> Source: Headstart 2019

- Overall, students in Year 8 reported more difficulties and had a less positive appraisal of their wellbeing compared to when they were in Year 7. However, they did report an improvement in their relationships with peers.
- Year 9 students reported less difficulties and had a better appraisal of their wellbeing compared to Year 9 students in the previous year, except for categories of school support and helping others.

#### Conclusions

Serious mental health conditions are particularly high in Thanet CCG, and higher than the Kent average in South Kent Coast and Canterbury & Coastal CCGs. The recorded prevalence in the population has been increasing, and there is a considerable difference with deprivation. The rate of increase has been seen to be double in the most deprived part of the population than the least.

Hospital admissions for mental health conditions is higher in Canterbury & Coastal CCG and Thanet CCG than the Kent average. Admissions have been reducing faster in Kent than England. The most deprived depravation quintile across Kent has seen a steeper reduction than the least deprived, but despite this the rate of admissions in the most deprived is more than double the least.

The recorded prevalence of depression in adults has increased by over 1% per year over the past 5 years in Kent, with Ashford, Canterbury & Coastal and Thanet CCGs above the Kent average. The rate of change has been larger in the most deprived, with a 1.06% annual prevalence increase in the most deprived compared to 0.82% in the least.

Suicide rates have been shown to be significantly higher in the most deprived parts of the population, affect roughly 3 times more males than females and occur in the highest rates in the 45-55, 35-45 and 55-65 age groups. Rates have largely been similar over the last 5 years, but Thanet CCG has seen recent increases for males and females, and South Kent Coast CCG in females. It must, however, be noted that low numbers can mean higher short-term variations are possible.

Self-harm in young people has shown a small overall decline but is increasing for females aged 13-16 and 17-20.

It is important that there is enough early help and preventative services for young people to prevent young people getting into crisis – these include trauma informed youth services, opportunities for young people to have a trusted supportive adult to confide in, good support for families and parents, support for parents in distress, provision for youth arts and drama, music and sport facilities linked to wellbeing – particularly in the more deprived areas of East Kent.

#### **Recommendations for Mental Health:**

- Create Local Place Based Partnership Plans to tackle health inequalities and wellbeing in the areas of greatest vulnerability.
- Ensure there are no barriers to mental health care and support for BAME people embed equity audits in delivery and commissioning.
- Create a whole system approach to 'social prescribing' and connecting people to the assets and networks that exist in their communities to enhance wellbeing.
- Commission services that are Adverse Childhood Experiences aware and workers are trained to understand the underlying issues as part of their work. Commissioners and providers will need to ensure training and supervision are core to delivery.
- Tackle the issue of social isolation in people of all ages in Kent. Use the combined assets and commissioning resources across the public sector to increase opportunities to reduce social isolation in the vulnerable population in Kent.
- Ensure that there is equity and ease of access for NHS Psychological Services
- Ensure that there is high quality joined up care for those needing community mental health services ensure this care is joined up between primary and specialist services with flexible and agile care co-ordination in place for vulnerable people.
- Ensure the health of people on the SMI register is tackled proactively.
- Ensure no barriers for care, treatment and support exist for those with co-occurring conditions (substance misuse and mental illness).
- Tackle the increasing prevalence in severe depression by ensuring care and support is joined up including good patient awareness of the pathway.
- Ensure that there are high quality and accessible information available to people in distress.
- Ensure all services are Trauma Informed and able and equipped to deal with a persons distress
- Promote wellbeing via six ways to wellbeing or similar
- Focus on Thanet and ensure the population of Thanet have high quality and accessible mental health services and a well supported voluntary and community sector.
- Understand better the interventions for crisis care and how these can be linked to a persons ongoing treatment options in order to prevent the second crisis.
- Work across all systems to share different agencies learning from serious incidents and near misses so the system can mature and learn.
- Ensure there is good quality patient advocacy in place.

#### **10.9 Dementia**

The term 'dementia' is used to describe a syndrome, resulting in progressive decline in multiple areas of function such as decline in memory, reasoning, communication skills and the ability to carry out daily activities. The individual with dementia may also develop behavioural and psychological symptoms such as depression and psychosis.

Recorded prevalence of dementia in Canterbury & Coastal, South Kent Coast and Thanet CCGs is higher than the Kent average, whereas the prevalence in Ashford CCG is lower than the Kent average. There is variability across wards, the following show significantly higher rates than their CCG average:

Ashford CCG:

- Weald South
- St Michaels
- Tenterden South
- Tenterden North
- Rolvenden & Tenterden West
- Isle of Oxney
- Weald Central
- Biddenden

#### Canterbury & Coastal CCG:

- Herne & Broomfield
- Heron
- Greenhill & Eddington
- West Bay
- Reculver

- North Nailbourne
- Little Stour
- Barham Downs
- Chestfield & Swalecliffe

South Kent Coast CCG:

- Hythe West
- North Downs East
- Hythe East
- New Romney Town

#### Thanet CCG:

- Westgate-on-sea
- Dane Valley
- Cliftonville West

#### Figure 4571: Recorded prevalence of dementia – by CCG (of registration)

#### Recorded prevalence of dementia: by CCG

Percentage of patients (all ages) recorded on QOF GP registers as having dementia, 2017/18



Source: QOF, prepared by KPHO (RK), Jan-19

#### Figure 458: Recorded prevalence of dementia – by ward



Figure 459:

### Percentage of patients recorded on GP QOF registers as having dementia, all ages, modelled ward-level estimates, 2015/16-2017/18 Chestfield & Swalecliffe Reculve Harbo West Ba Та Greenhill & Eddingto Seasalte Herne & Broomfield Little Stour Percentage Greater than 1.0 0.8 to 1.0 North Nailb 0.8 to 0.8 0.6 to 0.8 Less than 0.6

Source: QOF, prepared by KPHO (MP), Nov-18

#### Figure 460



#### Recorded dementia prevalence: by electoral ward

#### Figure 461



The recorded prevalence of dementia in people aged 65+ is 3.91% in Kent (in 2017/18). The estimated dementia diagnosis rate for Kent is 61.7% based on the recorded prevalence in primary care vs the estimated prevalence in the population from the Cognitive Function and Ageing Study II<sup>51</sup>. This equates to an estimate of around 9,600 in East Kent, and with 6,000 recorded in the latest QoF figures from 2017/18 there are an estimated 3,600 undiagnosed in the populace.

<sup>&</sup>lt;sup>51</sup> <u>https://fingertips.phe.org.uk/profile-group/mental-</u>

health/profile/dementia/data#page/6/gid/1938133052/pat/6/par/E12000004/ati/102/are/E06000015/iid/929 49/age/27/sex/4



Recorded dementia prevalence in East Kent is increasing gradually by around 0.07% per year, reflecting the trend for England. This equates to around 500 patients per year for East Kent, although the last 3 recording periods in the QoF between 2014/15 and 2017/18 have been stable after larger increases seen in 2012/13 and 2013/14. The prevalence and rate of change is similar by deprivation.

#### Dementia diagnosis rate: CCG

#### Figure 463: Recorded prevalence of dementia – deprivation



Source: QOF, prepared by KPHO (MP), Nov-18

#### **Conclusions:**

Dementia is a costly and increasing condition with implications for families, carers and public services as the population inexorably grows older. In East Kent, Canterbury & Coastal, South Kent Coast and Thanet CCGs have higher recorded rates than the rest of the county. This may reflect some of the older population living in these areas as it has not been shown to vary much with deprivation.

An estimated 9,600 people age 65+ have the condition in East Kent, with approximately 3,600 undiagnosed. The prevalence is expected to increase as the population ages, with regression analysis from the last 5 years QoF data showing an increase of 500 patients per year, although the last 3 years have not shown increases.

#### **Recommendations:**

KCC has commissioned a range of services and support for People Living with Dementia and their Families/Carers to promote inclusive, Dementia Friendly Communities where people living with dementia and their carers are active participants within community life.

Develop an evaluation of existing services to determine the impact of dementia friendly initiatives on health and social care demand and establish the case for further investment in this area.

Awareness of practices with higher rates of Dementia and appropriate structure of their services.

Ensure good prevention is available "what's good for the heart is good for the head" campaign for vascular dementia.

### **10.10 Learning Disability**

The term 'learning disability' (LD) commonly refers to a group of individuals with a history of developmental delay, a delay in or failure to acquire a level of adaptive behaviour and/or social functioning expected for their age and in whom there is evidence of significant intellectual impairment. Individuals with LD have an increased risk of early death and the risk of dying before the age of 50 has been found to be 58 times greater than in the general population. People with Down's syndrome have a higher incidence of medical problems than the general population; 30-45% have congenital heart disease; 6% have gastrointestinal anomalies; 1% develop childhood leukaemia; there is an increased incidence of hypothyroidism; the majority of individuals develop early-onset dementia; 70% have hearing problems; 50% have sight difficulties and many have increased levels of severe periodontal disease (Learning Disability JSNA 2010).

The recorded prevalence of LD in higher than Kent in South Kent Coast and Thanet CCGs, similar to Kent in Canterbury & Coastal and lower than Kent in Ashford CCG. There is high variability across wards, with the following significantly higher than their parent CCG average:

Ashford CCG:

- Weald South
- Saxon Shore
- Isle of Oxley
- Weald North
- Biddenden
- Weald Central

#### Canterbury & Coastal CCG:

- Little Stour & Ashbourne
- Marshside
- Northgate

South Kent Coast CCG:

- Lydd
- New Romney Town
- New Romney Coast
- Castle
- Dymchurch and St Mary's Bay

#### Thanet CCG:

- Westbrook
- Garlinge

### KENT PUBLIC HEALTH )BSERVATORY

#### Figure 464: Recorded prevalence of learning disabilities – by CCG (of registration)



Source: QOF, prepared by KPHO (RK), Jan-19

#### Figure 465: Recorded prevalence of learning disabilities - by ward





#### Figure 466

#### Recorded prevalence of learning disabilities: by electoral ward

Percentage of patients recorded on GP QOF registers as having a learning disability, modelled ward-level estimates, 2015/16-2017/18



Source: QOF, prepared by KPHO (MP), Nov-18

#### Figure 467

#### Recorded prevalence of learning disabilities: by electoral ward

Percentage of patients recorded on GP QOF registers as having a learning disability, modelled ward-level estimates, 2015/16-



#### Figure 468



Emerson et al<sup>52</sup> estimated in 2004 that nationally the prevalence of LD was around 2% of the general population, and that just under a quarter (0.47%) of these were known users of LD services. The figure below estimates the gap between expected and recorded prevalence of learning disabilities, this may equate to as many as 24,000 undiagnosed cases across Kent in 2016/17 of varying severities.

<sup>&</sup>lt;sup>52</sup> <u>https://www.lancaster.ac.uk/staff/emersone/FASSWeb/Emerson\_08\_PWLDinEngland.pdf</u>



#### Figure 469: Recorded and expected prevalence of learning disabilities

Source: Emerson 2004, PCIS, QOF, prepared by KPHO (ZC), August 2018

Uptake of health checks amongst people with learning disabilities in Kent is lower than the England average, with Thanet CCG significantly lower than the Kent uptake rate. Uptake of seasonal flu vaccination in the four East Kent CCGs were similar to the Kent and England levels. Cervical screening in females aged 24 to 64 with a learning disability in low nationally and locally in Kent. The East Kent CCGs all have similar uptake rates to both.





Source: NHS Digital, prepared by KPHO (ZC), August 2018



#### Figure 471: Seasonal influenza vaccination of people with learning disabilities

Source: NHS Digital, prepared by KPHO (ZC), August 2018



South Kent Coast

Swale

Thanet

Dartford,

Gravesham and Swanley

#### Figure 472: Uptake of cervical screening in people with learning disabilities

Source: NHS Digital, prepared by KPHO (ZC), August 2018

Ashford

Canterbury and

Coastal

#### **Conclusions:**

It has been shown that there is a large proportion of the general population with undiagnosed learning disability, although the severity of the condition varies from mild where the person may be able to lead a full, independent life to those with profound and multiple learning disabilities who require full time care and support. Nationally, it is thought approximately 23% of learning disabilities are severe. The recorded prevalence has been shown to vary considerably in Kent, with South Kent Coast and Thanet CCGs showing a higher rate than the Kent average.

LD health check uptake was low, and variable by CCG (with South Kent Coast having the highest rate in Kent). Uptake rate is thought to be better in areas of higher recorded prevalence. Similarly, flu vaccination rates were higher in South Kent Coast than the rest of Kent.

West Kent

#### **Recommendations:**

GP practices should sign up for the DES LD annual health check since this facilitates early intervention for the management of Long-term Conditions.

More work should be done with the primary care teams to actively case find persons with learning disability particularly in those practices with low prevalence.

The provision of healthy diet and adequate opportunity for physical activity within residential accommodation for persons with learning disabilities should be appraised and the Service Level Agreements adjusted to maximise such healthy living opportunities – led by Adult Social Services.

All agencies should be rigorous in assuring that persons with learning disability receive appropriate services with regard to sight and hearing, in recognition that their population needs are predicted as being greater than the general population.

Ensure that all people with LD have a health check each year and a safety plan for COVID19.

#### **10.11** Having More than One Long-term Condition: Multimorbidity

Multimorbidity is defined as an individual with two or more QoF recorded long-term conditions.

It is strongly linked with age, and as the population ages the burden and cost of multimorbidity is highly likely to increase. Around 100,000 people, or **22.1%** of the adult population age 25+ are multimorbid in East Kent, nearly 2% higher than the Kent figure of 20.3%. After standardising for age differences, East Kent still has a higher proportion of its population that is multimorbid.

Based on the 60 East Kent practices flowing data into the KID at the time of analysis, multimorbidity prevalence in **Thanet CCG was higher than the Kent average** and higher than the East Kent average.

There are four practices in Ashford CCG, 6 practices in Canterbury & Coastal CCG, 15 practices in South Kent Coast CCG and 9 practices in Thanet CCG all with a significantly higher recorded prevalence of multimorbidity than the Kent average.

Analysis of multimorbidity (2 or more long-term conditions) has been conducted using data from the Kent Integrated Dataset (KID). Please see the <u>methodology section</u> for further details.

Based on the 59 East Kent practices flowing data into the KID at the time of analysis, multimorbidity prevalence in Ashford CCG, Canterbury & Coastal CCG, South Kent Coast CCG and Thanet CCG were all higher than the Kent average and higher than the East Kent average with the exception of Canterbury & Coastal CCG and Ashford CCG has a similar multimorbidity prevalence to East Kent average.

The total number of morbidities and the proportion of people with multimorbidity increases with age; see figure 473. Amongst adults living in East Kent, multimorbidity prevalence also increases with the deprivation of the area in which people live. Figure 478 shows quinary age band and deprivation quintile.

There are 4 practices in Ashford CCG, 4 practices in Canterbury & Coastal CCG, 12 practices in South Kent Coast CCG and 8 practices in Thanet CCG with a significantly higher recorded prevalence of multimorbidity than the Kent average.



#### Figure 473: Recorded multimorbidity prevalence – by CCG (of registration)



#### Figure 474: Recorded multimorbidity prevalence - by GP practice



#### Figure 476







#### Figure 478: Recorded multimorbidity prevalence – by age and deprivation

#### 10.11.1 Long-term Condition Combinations

Across Kent, 7.4% of those registered with a GP flowing data into the Kent Integrated Dataset (KID) at the time of the analysis are recorded by their GPs as having both hypertension and obesity. Other common combinations of multimorbidity in Kent are obesity and depression (4.8%), diabetes and hypertension (3.9%), diabetes and obesity (3.5%) and depression and hypertension (3.3%).



#### Figure 479: Recorded multimorbidity prevalence – disease combinations (Kent)

#### **Conclusions:**

Multimorbidity is a growing health problem and is important from a public health perspective because of the enormous challenges that it brings both for patients and GP s. A high proportion of healthcare resource is used for caring for people with multiple long-term conditions and it is becoming increasingly necessary to find innovative ways of managing multiple conditions more effectively, and of being more proactive in their prevention.

The latest Multimorbidity analysis using East Kent GP data indicates the most common combination of morbidities are: i) hypertension and obesity, ii) obesity and depression, iii) hypertension and Diabetes, v) hypertension and depression and iv) Diabetes and obesity. Thanet CCG has the highest rate of adults who are multimorbid in East Kent. Again, deprivation is strongly linked with multimorbidity, and the deprivation gap is the widest in those aged 60 to 75.

#### **Recommendations:**

Further research is required to explore patterns of multimorbidity in East Kent population should facilitate improved primary care management including prescribing

The Kent Public Health Observatory intends to do further work to analyse multimorbidity and analyse further the interplays between different long-term conditions, their causes and consequences.

It is clear that tackling health conditions together – wrapping care around the individual

is the key to better health care for the population.

Ensuring mental health care is integrated into the treatment of depression, hypertension and obesity and vascular pathways would go some way to joined up care for an individual.

### 11 | Variations in Quality and Outcomes Framework Recorded Conditions

This chapter presents the variations in recorded disease prevalence for 14 QoF conditions. Prevalence rates have been adjusted for practice list size in order to eliminate the confounding effect of prevalence variations that may driven by differences in practice size. Other factors such as underlying epidemiology, socio-demographics and list demographic structure have not been adjusted for due to data limitations.

#### Methodology

Simple linear regression was used to 'standardise' or adjust disease specific prevalence counts based on the relevant practice denominator used to derive the crude rate based on the parent CCG's rate for each disease. The resultant predicted or 'expected' values were used to derive the ratio given by o/e (observed/expected). The ratio provides an indexed value whereby values above 1 are more than expected and values less than 1 are less than expected.

#### Results

The results are presented in the box and whisker plot charts below which show the median (mid line), interquartile (the boxes, accounting for 50% of practices in the sample) and outlier distributions (the 'whisker' lines, 1.5 x the interquartile range). Circles outside the whiskers indicate extreme outliers.

Certain conditions show greater degrees of variation than others. Across East Kent (ignoring extreme outliers), learning disability, COPD, heart failure, chronic kidney disease and dementia show the widest variations, and hypertension, asthma, diabetes, CHD and stroke show the least.

Looking at individual CCGs the patterns of variation are different. For Ashford CCG the most variation can be seen in dementia, learning disability, atrial fibrillation, CHD and stroke, and the least variation in diabetes, asthma, hypertension, COPD, and hearth failure.

In Canterbury & Coastal CCG the most variation can be seen in learning disability, dementia, cancer, COPD and serious mental health conditions. The least variation in depression, CHD, hypertension, asthma and stroke.

For South Kent Coast CCG, the widest variations were in learning disability, COPD, atrial fibrillation, serious mental health and depression and the least in diabetes, asthma, hypertension, heart failure and cancer.

In Thanet CCG the most variation was in learning disability, dementia, serious mental health, COPD and CHD, the least in diabetes, asthma, hypertension, atrial fibrillation and heart failure.

Some of reasons for the more extreme outlying practices may include: recording variations, a high student population or a high proportion of care homes being supported by the practice.



#### Figure 481





#### Figure 483





### **12** | Conclusions

The East Kent population is living longer and developing more multiple long-term conditions and frailty. The overall population is expected to increase by 19% for Kent over the next 20 years, however the numbers of over 65's are expected to increase by around 50% and over 85's are expected to double. This is likely to have profound consequences on the ability of services to deliver with current rates of funding and will likely see rises across a range of health conditions linked to old age, especially cancer, cardiovascular diseases and dementia as well as an increase in overall frailty and multimorbidity in the population.

Many of the conditions discussed in this needs assessment affect older people and are likely to increase as the population ages. Multimorbidity and frailty indexes are also likely to increase concurrently with these conditions. People with one or more long-term conditions (around 29% of the population) use 50% of GP appointments; 58% of A&E attendances; 59% of practice nurse appointments; 64% of outpatient appointments; and 70% of inpatient days, (Kings Fund 2011). Evidence suggests that prevalence of multi-morbidity increased substantially with age (most people with age 65 and over). There is also evidence to suggest that there is early onset of multi-morbidity in most deprived areas compared with most affluent (Barnett et al 2012). It is becoming increasingly necessary to find innovative ways of managing multiple conditions and frailty more effectively, and of being more proactive in their prevention.

With these demographic pressures it is vital that healthcare services adopt a more joined up, population health-based preventative approach as has been highlighted in the recent NHS 10-year plan, with a greater focus on the wider determinants of health and tackling inequalities. The K&M STP is already taking the lead in shaping local services into new integrated care partnerships and primary care networks. The government is yet to declare its intentions for the future of social care, but it is hoped adequate resource will be given to help support the intentions of the NHS long term plans.

**Deprivation remains a key predictor of poor health outcomes and mortality in East Kent.** Kent is a prosperous county but one of wide social contrast. Throughout this needs assessment deprivation has been shown to be a key predictor for a wide range of poor health outcomes and mortality. These inequalities are particularly apparent in life expectancy, premature mortality, child obesity, A&E usage, smoking, alcohol and substance misuse related issues and diabetes, The question for healthcare services is how much resource to use and how best to utilise it to tackle some of the widening inequalities.

On current trends several long-term conditions, recorded in primary care, have been shown to be increasing in East Kent and will likely add to demand for services in the short to mid-term, or have shown significant variation with deprivation:

- Diabetes prevalence is close to 7% and increasing at around 0.1% per year, with just under 1,000 more diagnosed patients expected annually and a 30% higher rate in the most deprived.
- Recorded COPD is 75% more prevalent in the most deprived part of the population than the least, and diagnosis have been increasing at nearly treble the rate. In total 600 more people per year could be expected to need support.
- Depression is a particularly rapidly increasing condition with a 1.2% expected annual prevalence increase based on the previous few years data. Across East Kent this has been a 6-7,000 increase per year. It is not likely this rapid increase will continue at this pace, and it is also worth noting that as depression is transient in nature, primary care may not always be informed if a patient has recovered.
- Atrial fibrillation diagnoses are increasing quickly with an observed 0.11% prevalence increase from recent years, roughly 1,000 patients annually. It is more prevalent and growing faster in the least deprived populations, suggesting there could be more undiagnosed people in more deprived areas.
- The proportion of the population living with cancer is increasing by around 0.2-0.25% per year, roughly 1,800 patients annually for East Kent. The least deprived quintile of the population have a higher prevalence of around 25% and are increasing 20% faster than the most deprived.
- Dementia diagnoses are increasing modestly by around 0.07% per year, approximately 500 per year. Close to 10,000 people live with the condition in East Kent and it's estimated another 3-4,000 are currently undiagnosed.
- Hypertension prevalence is increasing at 0.2% per year, equating to approximately 2,000 people. It is a highly prevalent condition already and it is estimated 85 90% of hypertensive patients now have a diagnosis.
- Serious mental health conditions have been growing in prevalence by about 0.03% annually, or 250 300 more people needing support each year.

There is some evidence that lifestyle choices are changing but they continue to play a key role in health on an individual level, and a populations morbidity and mortality rates can vary significantly if higher proportions make unhealthy choices.

- Smoking in East Kent has been declining in recent years as it has been nationally but is still the leading cause of preventable mortality and an estimated 100,000 people in East Kent still smoke. Smoking is strongly linked with deprivation and manual work, and smoking in pregnancy remains a key concern. E-cigarette use is now being encouraged as an aid to quit tobacco smoking.
- There is some evidence to suggest overall alcohol consumption is falling in the population, but not amongst older and more problematic drinkers. Survey data suggests around 40,000 people in East Kent could be regularly drinking more than 35 units per week. Rates of alcohol specific and related mortality is largely unchanged over the last few years.

- There is also evidence to suggest drug use is falling in the population, although in more recent years the rate of decline may have stalled and has not been seen in older drug users or those on harder drugs. Drug related mortality has been increasing, and has shown significant, recent spikes in Thanet, Folkestone & Hythe and Canterbury.
- Adult obesity has been steadily increasing in recent years is a growing area of concern for long-term population health, particularly as many of the related health consequences e.g. diabetes, CVD and cancer can take many years to manifest. Regional survey data suggest 27-30% of the population are obese across East Kent, which are more likely to have health implications. This equates to upwards of 150,000 adults and recent trends suggest this will continue to increase.

Children and young people have a different set of needs than adults, and this needs assessment has identified childhood obesity and excess weight, A&E attendances, chlamydia and some mental health and self-harm issues as the key areas of increase and concern. Infant mortality, low birth weight, breastfeeding uptake, teenage conceptions and vaccination rates are all important issues but have not showed signs of significant deterioration.

### **13** | Recommendations

There are a series of recommendations for health needs in this Needs Assessment and it will be important to digest these. The importance of needs assessment is stated in the 2012 Health and Social Care Act and this forms part of the Joint Strategic Needs Assessment process for Kent and Medway.

This must go hand in hand with **health care demand modelling and assessment**. The purpose of demand modelling is to turn the needs into deliverable health and social care activities that go towards meeting the needs of the population.

It is important for commissioners and providers to understand the needs and then turn these needs into questions that can be addressed by demand modelling e.g

<u>Given the rise in over 65 people with obesity and depression – if a service that was delivered</u> <u>in primary care and offered long term and routine management of both conditions – how</u> <u>long would that service need to be in place before it became value for money?</u>

Only focusing on demand – will be to miss the changing and growing needs of the population and only focusing on the needs assessment will be frustrating as no one solution to multiple needs is available when health care is scarce.

With that in mind there are some **broad recommendations from this needs assessment:** 

- Considering the projected population growth it is essential that Commissioners prevent ill health through primary prevention as well as commission services for secondary and tertiary prevention.
- Given the increasing complexity of health needs, the context of COVID19 and the health inequities in East Kent – ensure the whole WORKFORCE is supported, has training and supervision and development on prevention, professional curiosity and is mental health Trauma Informed.
- Given the variations across Kent and East Kent ensure that equity audit cycle is built into both commissioning and delivery.
- Given that 55% of all people over 60 will have over 2 Long Term Conditions ensure that delivery of care and commissioning of care is focused on the needs of the patient and managed proactively and in a joined up fashion.
- Given that there are some health needs that are below England average These should be priority areas for improvement in both treatment and prevention:
  - Mental Health
  - Obesity and Vascular Health
  - Maternal Health and health of baby.
  - Cancer Treatment and Prevention.

#### A Note on Health Promotion and Prevention

It is the recommendation of this needs assessment that East Kent have an Enhanced Preventative Health focus.

The current plans include:

- Delivering workplace health initiatives, aimed at improving the health of staff delivering services
- Industrialising clinical treatments related to lifestyle behaviours and treating these conditions as clinical diseases
- Treating both physical and mental health issues concurrently and effectively
- Concentrating prevention activities in four key areas which are described below.

The main areas for focus for prevention activities in Kent and Medway have been identified and are:

#### **Obesity and Physical Activity:**

Apply a whole systems approach including implementation of 'Let's Get Moving' physical activity pathway in primary care at scale across Kent and Medway. Increase capacity in Tier 2 Weight Management Programmes from 2,348 to 10,000.

#### Smoking Cessation and Prevention:

Acute trusts becoming smoke-free with trained advisors, tailored support for the young and youth workers, pregnant and maternal smokers and people with mental health conditions.

#### Workplace Health:

Working with employers on lifestyle interventions and smoking and alcohol misuse, providing training programmes for improved mental health and wellbeing in the workplace

#### **Reduce Alcohol-Related Harms in the Population:**

'Blue Light initiative' addressing change-resistant drinkers. 'Identification and Brief Advice' (IBA) in hospitals ('Healthier Hospitals initiative') and screening in GPs. Alcohol health messaging to the general population.

### Appendix A – GP practice and Ward population profiles

The graphs below show the registered GP practice populations presented by CCG and provisional primary care network. Below these are tables showing the percentage of the population resident in each Ward in East Kent registered with particular GPs<sup>53</sup>. For each Ward, GPs serving at least 5% of the population are listed.



<sup>&</sup>lt;sup>53</sup> Source: NHS Digital, July 2019




Ward Populations I	by main GP Prac	tices - A	shford C	CG
Mond None	Dreatice Code	Link	Detiente	% of ward
ward Name	Practice Code	HUD	Patients	population
Aylesford Green	G82080	North	2902	67.9%
Aylesford Green	G82050	South	969	22.7%
Beaver	G82080	North	3557	51.2%
Beaver	G82050	South	2628	37.8%
Biddenden	G82114	Rural	1100	97.8%
Bockhanger	G82087	North	1873	68.4%
Bockhanger	G82050	South	349	12.7%
Bockhanger	G82080	North	178	6.5%
Boughton Aluph & Eastwell	G82087	North	2120	58.1%
Boughton Aluph & Eastwell	G82142	North	726	19.9%
Boughton Aluph & Eastwell	G82050	South	421	11.5%
Boughton Aluph & Eastwell	G82080	North	191	5.2%
Bybrook	G82087	North	2161	73.3%
Bybrook	G82050	South	338	11.5%
Bybrook	G82080	North	168	5.7%
Bybrook	G82142	North	152	5.2%
Charing	G82094	North	2624	98.5%
Downs North	G82142	North	701	87.5%
Downs North	G82094	North	84	10.5%
Downs West	G82094	North	1833	69.7%
Downs West	G82142	North	415	15.8%
Downs West	G82087	North	184	7.0%
Godinton	G82087	North	3345	39.3%
Godinton	G82050	South	2137	25.1%
Godinton	G82080	North	1180	13.8%
Godinton	G82049	North	759	8.9%
Godinton	G82094	North	747	8.8%
Great Chart with Singleton North	G82080	North	2359	59.4%
Great Chart with Singleton North	G82050	South	588	14.8%
Great Chart with Singleton North	G82730	South	447	11.3%
Great Chart with Singleton North	G82094	North	250	6.3%
Highfield	G82080	North	1916	75.9%
Highfield	G82050	South	315	12.5%
Isle of Oxney	G82114	Rural	1524	56.9%
Isle of Oxney	G82186	Rural	827	30.9%
Isle of Oxney	G82053	Rural	322	12.0%
Kennington	G82087	North	1484	64.3%
Kennington	G82142	North	320	13.9%
Kennington	G82050	South	255	11.0%
Kennington	G82080	North	153	6.6%
Little Burton Farm	G82087	North	2205	66.3%
Little Burton Farm	G82050	South	381	11.5%
Little Burton Farm	G82080	North	330	9.9%
Little Burton Farm	G82142	North	293	8.8%

Ward Populations b	by main GP Prac	tices - A	shford C	CG
Mond Neme	Prestice Code	Link	Detiente	% of ward
ward Name	Practice Code	HUD	Patients	population
Norman	G82050	South	1561	49.7%
Norman	G82080	North	1100	35.0%
Norman	G82730	South	219	7.0%
North Willesborough	G82080	North	3647	64.5%
North Willesborough	G82050	South	928	16.4%
North Willesborough	G82087	North	500	8.8%
North Willesborough	G82142	North	352	6.2%
Park Farm North	G82730	South	1645	78.4%
Park Farm North	G82050	South	186	8.9%
Park Farm North	G82080	North	158	7.5%
Park Farm South	G82730	South	3940	78.3%
Park Farm South	G82050	South	399	7.9%
Park Farm South	G82080	North	389	7.7%
Rolvenden & Tenterden West	G82114	Rural	2115	98.7%
Saxon Shore	G82658	North	2064	37.2%
Saxon Shore	G82186	Rural	1798	32.4%
Saxon Shore	G82142	North	1184	21.4%
Singleton South	G82080	North	2001	61.3%
Singleton South	G82050	South	521	16.0%
Singleton South	682730	South	436	13.0%
South Willesborough	682080	North	-30 2877	72 7%
South Willesborough	682050	South	752	19.0%
St Michaels	G82050	Rural	2307	96.2%
Stanhono	682114	North	2507	50.270 65.4%
Stanhope	682080	South	1002	05.4% 26.1%
Stanhope	682030	South	220	20.170 5 5%
Staur	682730	South	230	2.270 20.29/
Stour	G82050	North	2371	39.3% 33.3%
Stour	G82087	North	2010	33.3% 14.6%
Stour	G82060	North	0/9 E40	14.0%
Tenterden Nerth	G82049	Dural	248 2102	9.1%
Tenterden North	G82114	Rural	2183	98.4%
Vistaria	G82114	Rurai	2423	96.2%
	G82050	South	3270	47.7%
	G82080	North	16/1	24.4%
Victoria	G82049	North	747	10.9%
Victoria	G82087	North	/11	10.4%
Washford	G82730	South	1/46	41.9%
Washford	G82080	North	1687	40.5%
Washford	G82050	South	555	13.3%
Weald Central	G82114	Rural	2111	40.5%
Weald Central	G82094	North	1962	37.7%
Weald Central	G82053	Rural	961	18.4%
Weald East	G82730	South	1704	40.2%
Weald East	G82080	North	1015	23.9%
Weald East	G82658	North	468	11.0%
Weald East	G82050	South	384	9.1%
Weald East	G82186	Rural	302	7.1%
Weald East	G82142	North	234	5.5%
Weald North	G82094	North	897	96.7%
Weald South	G82186	Rural	2695	44.7%
Weald South	682053	Rural	2111	35.0%
Weald South	G82730	South	674	11.2%
Wye	G82142	North	2663	95.4%

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Ward Populations by	main GP Practio	ces - Canterbury 8	& Coastal	CCG
Ward Name	Practice Code	Hub	Dationts	% of ward
			ratients	population
Abbey	G82039	Faversham	3577	55.6%
Abbey	G82027	Faversham	2728	42.4%
Barton	G82082	Canterbury and rural	4288	24.6%
Barton	G82115	Canterbury and rural	4054	23.2%
Barton	G82802	Canterbury and rural	2661	15.3%
Barton	G82228	Canterbury and rural	2649	15.2%
Barton	G82060	Canterbury and rural	2642	15.1%
Barton	G82140	Canterbury and rural	928	5.3%
Beltinge	G82119	Herne Bay	2488	49.5%
Beltinge	G82090	Herne Bay	2353	46.8%
Blean Forest	G82140	Canterbury and rural	9060	59.1%
Blean Forest	G82060	Canterbury and rural	2154	14.0%
Blean Forest	G82228	Canterbury and rural	1908	12.4%
Boughton & Courtenay	G82039	Faversham	5095	60.7%
Boughton & Courtenay	G82027	Faversham	1683	20.1%
Boughton & Courtenay	G82071	Whitstable	811	9.7%
Chartham & Stone Street	G82790	Canterbury and rural	2389	38.5%
Chartham & Stone Street	G82060	Canterbury and rural	1944	31.3%
Chartham & Stone Street	G82228	Canterbury and rural	942	15.2%
Chartham & Stone Street	G82115	Canterbury and rural	347	5.6%
Chestfield	G82071	Whitstable	5387	97.9%
East Downs	G82039	Faversham	1157	58.4%
East Downs	G82027	Faversham	766	38.7%
Eastry	G82063	Sandwich and Ash	3319	95.1%
Gorrell	G82071	Whitstable	11520	98.6%
Greenhill	G82119	Herne Bay	1588	41.4%
Greenhill	G82090	Herne Bay	1574	41.1%
Greenhill	G82071	Whitstable	616	16.1%
Herne & Broomfield	G82119	Herne Bay	6798	70.1%
Herne & Broomfield	G82090	Herne Bay	2419	25.0%
Heron	G82119	Herne Bay	8284	53.2%
Heron	G82090	Herne Bay	6354	40.8%
Little Stour & Adisham	G82228	Canterbury and rural	4473	79.1%
Little Stour & Adisham	G82115	Canterbury and rural	350	6.2%
Little Stour & Ashstone	G82138	Sandwich and Ash	3562	65.1%
Little Stour & Ashstone	G82063	Sandwich and Ash	949	17.3%
Little Stour & Ashstone	G82228	Canterbury and rural	667	12.2%
Nailbourne	G82228	Canterbury and rural	1962	81.6%
Nailbourne	G82115	Canterbury and rural	196	8.1%
Northgate	G82060	Canterbury and rural	3986	47.0%
Northgate	G82082	Canterbury and rural	1985	23.4%
Northgate	G82115	Canterbury and rural	792	9.3%
Northgate	G82228	Canterbury and rural	638	7.5%
Northgate	G82140	Canterbury and rural	600	7.1%

Ward Populations by	main GP Practio	ces - Canterbury 8	& Coastal	CCG
Word Name	Practice Code	Uub	Dationts	% of ward
Ward Name	Practice Code	пир	Patients	population
Priory	G82027	Faversham	1597	52.8%
Priory	G82039	Faversham	1404	46.5%
Reculver	G82090	Herne Bay	3470	75.5%
Reculver	G82119	Herne Bay	958	20.9%
Sandwich	G82063	Sandwich and Ash	6615	92.0%
Sandwich	G82138	Sandwich and Ash	517	7.2%
Seasalter	G82071	Whitstable	8717	97.7%
St Ann's	G82027	Faversham	2864	52.2%
St Ann's	G82039	Faversham	2568	46.8%
St Stephen's	G82140	Canterbury and rural	3332	32.6%
St Stephen's	G82060	Canterbury and rural	3207	31.4%
St Stephen's	G82228	Canterbury and rural	1486	14.6%
St Stephen's	G82115	Canterbury and rural	908	8.9%
St Stephen's	G82082	Canterbury and rural	830	8.1%
Sturry	G82082	Canterbury and rural	5402	54.3%
Sturry	G82060	Canterbury and rural	1336	13.4%
Sturry	G82090	Herne Bay	1140	11.5%
Sturry	G82228	Canterbury and rural	622	6.3%
Sturry	G82115	Canterbury and rural	518	5.2%
Swalecliffe	G82071	Whitstable	5496	81.4%
Swalecliffe	G82119	Herne Bay	612	9.1%
Swalecliffe	G82090	Herne Bay	576	8.5%
Tankerton	G82071	Whitstable	4373	98.4%
Teynham & Lynsted	G82039	Faversham	1404	56.7%
Teynham & Lynsted	G82027	Faversham	1037	41.8%
Watling	G82039	Faversham	2825	50.2%
Watling	G82027	Faversham	2727	48.5%
West Bay	G82119	Herne Bay	822	48.1%
West Bay	G82090	Herne Bay	681	39.9%
West Bay	G82071	Whitstable	192	11.2%
Westgate	G82228	Canterbury and rural	3229	31.7%
Westgate	G82060	Canterbury and rural	2196	21.5%
Westgate	G82140	Canterbury and rural	1797	17.6%
Westgate	G82082	Canterbury and rural	1268	12.4%
Westgate	G82115	Canterbury and rural	843	8.3%
Westgate	G82802	Canterbury and rural	703	6.9%
Wincheap	G82082	Canterbury and rural	1642	24.4%
Wincheap	G82060	Canterbury and rural	1537	22.9%
Wincheap	G82228	Canterbury and rural	1067	15.9%
Wincheap	G82115	Canterbury and rural	1018	15.1%
Wincheap	G82802	Canterbury and rural	893	13.3%

Ward Populations	by main GP Pra	ctices - South Kent	Coast CO	G
Ward Name	Bractico Codo	Hub	Pationts	% of ward
	Fractice Code	nus	Fallenis	population
Aylesham	G82211	Dover	4974	97.9%
Broadmead	G82121	Folkestone	1114	21.7%
Broadmead	G82232	Folkestone	867	16.9%
Broadmead	G82069	Folkestone	832	16.2%
Broadmead	G82091	Folkestone	728	14.2%
Broadmead	G82086	Folkestone	706	13.7%
Broadmead	G82760	Folkestone	461	9.0%
Broadmead	G82217	Folkestone	293	5.7%
Buckland	G82015	Dover	2116	27.1%
Buckland	G82117	Dover	1435	18.4%
Buckland	G82002	Dover	1410	18.0%
Buckland	G82128	Dover	1133	14.5%
Buckland	G82729	Dover	877	11.2%
Buckland	G82700	Dover	698	8.9%
Capel-le-Ferne	G82086	Folkestone	871	35.3%
Capel-le-Ferne	G82729	Dover	338	13.7%
Capel-le-Ferne	G82091	Folkestone	204	8.3%
Capel-le-Ferne	G82227	Dover	160	6.5%
Capel-le-Ferne	G82232	Folkestone	154	6.2%
Castle	G82015	Dover	1167	42.7%
Castle	G82002	Dover	661	24.2%
Castle	G82117	Dover	295	10.8%
Castle	G82128	Dover	286	10.5%
Castle	G82729	Dover	238	8.7%
Cheriton	G82069	Folkestone	7770	56.8%
Cheriton	G82121	Folkestone	2220	16.2%
Cheriton	G82091	Folkestone	914	6.7%
Cheriton	G82232	Folkestone	850	6.2%
Cheriton	G82086	Folkestone	686	5.0%
East Folkestone	G82086	Folkestone	5100	45.7%
East Folkestone	G82232	Folkestone	1661	14.9%
East Folkestone	G82091	Folkestone	1637	14.7%
East Folkestone	G82760	Folkestone	915	8.2%
East Folkestone	G82121	Folkestone	803	7.2%
East Folkestone	G82217	Folkestone	610	5.5%
Eastry	G82038	Deal	611	33.5%
Eastry	G82036	Deal	442	24.3%
Eastry	G82111	Deal	356	19.5%
Eastry	G82696	Deal	135	7.4%
Evthorne & Shepherdswell	G82729	Dover	1575	45.2%
Eythorne & Shepherdswell	G82227	Dover	857	24.6%
Evthorne & Shepherdswell	G82211	Dover	264	7.6%
Eythorne & Shepherdswell	G82117	Dover	217	6.2%

Ward NamePractice CodeHubPatients% of ward populationFolkestone CentralG82121Folkestone307331.2%Folkestone CentralG82232Folkestone257326.1%
Ward NamePractice CodeHubPatientspopulationFolkestone CentralG82121Folkestone307331.2%Folkestone CentralG82232Folkestone257326.1%
Folkestone CentralG82121Folkestone307331.2%Folkestone CentralG82232Folkestone257326.1%
Folkestone CentralG82232Folkestone257326.1%
Folkestone Central G82091 Folkestone 2473 25.1%
Folkestone Central G82086 Folkestone 624 6.3%
Folkestone Harbour G82091 Folkestone 2465 33.1%
Folkestone Harbour G82086 Folkestone 2164 29.0%
Folkestone Harbour G82232 Folkestone 1136 15.2%
Folkestone Harbour G82760 Folkestone 507 6.8%
Folkestone Harbour G82121 Folkestone 492 6.6%
Folkestone Harbour G82217 Folkestone 404 5.4%
Hythe G82160 Hythe/New Romney 6512 62.5%
Hythe G82018 Hythe/New Romney 2398 23.0%
Hythe G82121 Folkestone 598 5.7%
Hythe Rural G82160 Hythe/New Romney 3758 62.6%
Hythe Rural G82018 Hythe/New Romney 1699 28.3%
Lydden & Temple Ewell G82227 Dover 1369 56.0%
Lydden & Temple Ewell G82117 Dover 265 10.8%
Lydden & Temple Ewell G82002 Dover 262 10.7%
Lydden & Temple Ewell G82015 Dover 217 8.9%
Lydden & Temple Ewell G82128 Dover 159 6.5%
Maxton, Elms Vale & Priory G82729 Dover 2673 32.1%
Maxton, Elms Vale & Priory G82015 Dover 2336 28.0%
Maxton, Elms Vale & Priory G82002 Dover 1142 13.7%
Maxton, Elms Vale & Priory G82128 Dover 1035 12.4%
Maxton, Elms Vale & Priory G82117 Dover 905 10.9%
Middle Deal & Sholden G82036 Deal 3084 35.6%
Middle Deal & Sholden G82111 Deal 2418 27.9%
Middle Deal & Sholden G82038 Deal 2319 26.8%
Middle Deal & Sholden G82696 Deal 766 8.8%
Mill Hill G82036 Deal 2789 34.5%
Mill Hill G82038 Deal 2564 31.7%
Mill Hill G82111 Deal 2005 24.8%
Mill Hill G82696 Deal 690 8.5%
New Romney G82147 Hythe/New Romney 3820 51.4%
New Romney G82007 Hythe/New Romney 2996 40.3%
North Deal G82038 Deal 2209 32.3%
North Deal G82111 Deal 2204 32.2%
North Deal G82036 Deal 2154 31.5%
North Downs Fast G82165 Folkestone 8239 59.5%
North Downs East G82684 Folkestone 1764 12.7%
North Downs East G82652 Folkestone 1334 9.6%
North Downs West G82684 Folkestone 1610 64.1%
North Downs West 682652 Folkestone 657 26 1%
North Downs West G82165 Folkestone 187 7 40/
Ringwould 682111 Deal 768 30 1%
Ringwould (\$2036 Deal 675 24.4%
Bingwould G82038 Deal 416 21.2%

Ward Populations by main GP Practices - South Kent Coast CCG					
Ward Name	Practice Code	Hub	Patients	% of ward	
River	G82227	Dover	1725	37.8%	
River	G82015	Dover	676	14.8%	
River	G82002	Dover	539	11.8%	
River	G82117	Dover	496	10.9%	
River	G82128	Dover	445	9.7%	
River	G82729	Dover	323	7.1%	
Romney Marsh	G82665	Hythe/New Romney	4123	56.4%	
Romney Marsh	G82007	Hythe/New Romney	1950	26.7%	
Romney Marsh	G82147	Hythe/New Romney	670	9.2%	
Sandgate & West Folkestone	G82121	Folkestone	4033	60.1%	
Sandgate & West Folkestone	G82069	Folkestone	939	14.0%	
Sandgate & West Folkestone	G82232	Folkestone	470	7.0%	
St Margaret's-at-Cliffe	G82700	Dover	1592	30.7%	
St Margaret's-at-Cliffe	G82002	Dover	1006	19.4%	
St Margaret's-at-Cliffe	G82015	Dover	704	13.6%	
St Margaret's-at-Cliffe	G82038	Deal	494	9.5%	
St Margaret's-at-Cliffe	G82036	Deal	394	7.6%	
St Margaret's-at-Cliffe	G82111	Deal	259	5.0%	
St Radigunds	G82015	Dover	1674	27.8%	
St Radigunds	G82128	Dover	1116	18.5%	
St Radigunds	G82117	Dover	1029	17.1%	
St Radigunds	G82002	Dover	861	14.3%	
St Radigunds	G82729	Dover	666	11.1%	
St Radigunds	G82700	Dover	585	9.7%	
Tower Hamlets	G82015	Dover	2049	31.5%	
Tower Hamlets	G82128	Dover	1228	18.9%	
Tower Hamlets	G82117	Dover	1190	18.3%	
Tower Hamlets	G82002	Dover	1037	15.9%	
Tower Hamlets	G82729	Dover	766	11.8%	
Town & Pier	G82015	Dover	828	38.0%	
Town & Pier	G82002	Dover	395	18.1%	
Town & Pier	G82128	Dover	346	15.9%	
Town & Pier	G82729	Dover	301	13.8%	
Town & Pier	G82117	Dover	213	9.8%	
Walland & Denge Marsh	G82072	Hythe/New Romney	3604	53.0%	
Walland & Denge Marsh	G82147	Hythe/New Romney	1632	24.0%	
Walland & Denge Marsh	G82007	Hythe/New Romney	1241	18.3%	
Walmer	G82036	Deal	2991	40.4%	
Walmer	G82111	Deal	2627	35.5%	
Walmer	G82038	Deal	1389	18.8%	
Whitfield	G82117	Dover	1978	36.1%	
Whitfield	G82015	Dover	994	18.1%	
Whitfield	G82002	Dover	894	16.3%	
Whitfield	G82128	Dover	570	10.4%	
Whitfield	G82729	Dover	519	9.5%	
Whitfield	G82227	Dover	272	5.0%	

