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SOUTH KENT COAST HEALTH AND WELLBEING BOARD

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11 September 2016

Dear Member of the Health and Wellbeing Board

NOTICE IS HEREBY GIVEN THAT a meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** will be held in the Council Chamber at these Offices on Tuesday 20 September 2016 at 3.00 pm.

Members of the public who require further information are asked to contact Rebecca Brough on (01304) 872304 or by e-mail at rebecca.brough@dover.gov.uk.

Yours sincerely

Chief Executive

South Kent Coast Health and Wellbeing Board Membership:

Councillor P A Watkins (Chairman)	Dover District Council
Dr J Chaudhuri (Vice-Chairman)	South Kent Coast Clinical Commissioning Group
Councillor P M Beresford	Dover District Council
Ms K Benbow	South Kent Coast Clinical Commissioning Group
Councillor S S Chandler	Local Childrens Partnership Group Representative
Ms C Fox	Community and Voluntary Sector Representative
Councillor J Hollingsbee	Shepway District Council
Mr S Inett	Healthwatch Kent
Mr M Lobban	Kent County Council
Councillor M Lyons	Shepway District Council
Councillor G Lymer	Kent County Council
Ms J Mookherjee	Kent Public Health, Kent County Council

AGENDA

1 **APOLOGIES**

To receive any apologies for absence.

2 **APPOINTMENT OF SUBSTITUTE MEMBERS**

To note appointments of Substitute Members.

3 **DECLARATIONS OF INTEREST** (Page 4)

To receive any declarations of interest from Members in respect of business to be transacted on the agenda.

4 **MINUTES** (Pages 5 - 8)

To confirm the attached Minutes of the meeting of the Board held on 28 June 2016.

5 **MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD**

Any member of the Health and Wellbeing Board may request that an item be included on the agenda subject to it being relevant to the Terms of Reference of the Board and notice being provided to Democratic Services at Dover District Council (democraticservices@dover.gov.uk) at least 9 working days prior to the meeting.

6 **WORKFORCE STRATEGY** (Pages 9 - 25)

To consider the attached report.

Presenter: Tristan Godfrey, STP Workforce Programme Manager (Kent and Medway), Health Education England

7 **CHILDREN'S ARRANGEMENTS ACROSS KENT**

To consider the report (to follow).

Presenter: Helen Cook, Kent County Council

8 **INTEGRATED COMMISSIONING BOARD DEVELOPMENT UPDATE**

To receive a verbal update.

Presenter: Michelle Farrow, Head of Leadership Support, Dover District Council
Karen Benbow, Chief Operating Officer, South Kent Coast Clinical Commissioning Group

9 **EAST KENT STRATEGY BOARD UPDATE - TIME TO CHANGE**

To receive a presentation.

Presenter: Karen Benbow, Chief Operating Officer, South Kent Coast Clinical Commissioning Group

10 **DOVER AND SHEPWAY HEALTH PROFILES 2016** (Pages 26 - 33)

To consider the attached report.

Presenter: Jess Mookherjee, Public Health Consultant, Kent County Council

11 **HEALTH INEQUALITIES STRATEGY** (Pages 34 - 89)

To consider the report (to follow).

Presenter: Jess Mookherjee, Consultant in Public Health, Kent County Council

12 **URGENT BUSINESS ITEMS**

To consider any other items deemed by the Chairman to be urgent in accordance with the Local Government Act 1972 and the Terms of Reference. In such special cases the Chairman will state the reason for urgency and these will be recorded in the Minutes.

Access to Meetings and Information

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- All meetings are held at the Council Offices, Whitfield unless otherwise indicated on the front page of the agenda. There is disabled access via the Council Chamber entrance and a disabled toilet is available in the foyer. In addition, there is a PA system and hearing loop within the Council Chamber.
- Agenda papers are published five clear working days before the meeting. Alternatively, a limited supply of agendas will be available at the meeting, free of charge, and all agendas, reports and minutes can be viewed and downloaded from our website www.dover.gov.uk. Minutes are normally published within five working days of each meeting. All agenda papers and minutes are available for public inspection for a period of six years from the date of the meeting.
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Large print copies of this agenda can be supplied on request.

Declarations of Interest

Disclosable Pecuniary Interest (DPI)

Where a Member has a new or registered DPI in a matter under consideration they must disclose that they have an interest and, unless the Monitoring Officer has agreed in advance that the DPI is a 'Sensitive Interest', explain the nature of that interest at the meeting. The Member must withdraw from the meeting at the commencement of the consideration of any matter in which they have declared a DPI and must not participate in any discussion of, or vote taken on, the matter unless they have been granted a dispensation permitting them to do so. If during the consideration of any item a Member becomes aware that they have a DPI in the matter they should declare the interest immediately and, subject to any dispensations, withdraw from the meeting.

Other Significant Interest (OSI)

Where a Member is declaring an OSI they must also disclose the interest and explain the nature of the interest at the meeting. The Member must withdraw from the meeting at the commencement of the consideration of any matter in which they have declared a OSI and must not participate in any discussion of, or vote taken on, the matter unless they have been granted a dispensation to do so or the meeting is one at which members of the public are permitted to speak for the purpose of making representations, answering questions or giving evidence relating to the matter. In the latter case, the Member may only participate on the same basis as a member of the public and cannot participate in any discussion of, or vote taken on, the matter and must withdraw from the meeting in accordance with the Council's procedure rules.

Voluntary Announcement of Other Interests (VAOI)

Where a Member does not have either a DPI or OSI but is of the opinion that for transparency reasons alone s/he should make an announcement in respect of a matter under consideration, they can make a VAOI. A Member declaring a VAOI may still remain at the meeting and vote on the matter under consideration.

Note to the Code:

Situations in which a Member may wish to make a VAOI include membership of outside bodies that have made representations on agenda items; where a Member knows a person involved, but does not have a close association with that person; or where an item would affect the well-being of a Member, relative, close associate, employer, etc. but not his/her financial position. It should be emphasised that an effect on the financial position of a Member, relative, close associate, employer, etc OR an application made by a Member, relative, close associate, employer, etc would both probably constitute either an OSI or in some cases a DPI.

Minutes of the meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** held at the Council Offices, Whitfield on Tuesday, 28 June 2016 at 3.08 pm.

Present:

Chairman: Councillor P A Watkins

Councillors: Mr A Ball (as substitute for Councillor Ms C Fox)
Ms K Benbow
Dr J Chaudhuri
Councillor J Hollingsbee
Mr S Inett
Councillor M Lyons
Councillor G Lymer

Also Present: Ms R Jones (Director of Strategy and Business Development, East Kent Hospitals University NHS Foundation Trust)

Officers: Head of Leadership Support
Leadership Support Officer
Team Leader – Democratic Support

1 APOLOGIES

Apologies for absence were received from Councillor P M Beresford (Dover District Council), Councillor S S Chandler (Local Children's Partnership Group), Ms C Fox (Red Zebra), Mr M Lobban (Kent County Council) and Ms J Mookherjee (Kent Public Health).

The Board was advised that apologies for absence had also been received from Ms S Robson and Ms J Leney (Shepway District Council),

2 APPOINTMENT OF SUBSTITUTE MEMBERS

In accordance with the agreed Terms of Reference, it was noted that Mr A Ball had been appointed as substitute for Ms C Fox.

3 DECLARATIONS OF INTEREST

There were no declarations of interest made by members of the Board.

4 MINUTES

It was agreed that the Minutes of the Board meeting held on 17 May 2016 be approved as a correct record and signed by the Chairman.

5 MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD

There were no matters raised on notice by members of the Board.

6 SUSTAINABILITY AND TRANSFORMATION PLANS

Ms R Jones (Director of Strategy and Business Development, East Kent Hospitals University NHS Foundation Trust) presented the report on the Sustainability and Transformation Plans.

The Board was advised that the Sustainability and Transformation Plans (STP) had 5 key elements:

- Local leaders working as a team;
- A shared vision;
- A programme of a coherent set of activities;
- Execution against the plan; and
- Learning and adapting.

It was acknowledged that in respect of Kent and Medway there were still challenges given that local priorities had shaped areas within the county differently.

The STP would need to:

- Close the health and wellbeing gap;
- Drive transformation to close the care and quality gap; and
- Close the financial and efficiency gap.

It was intended that by the end of June 2016 there would be:

- An STP with the models of care required to meet key priorities clearly described;
- A prioritised approach to describing ambitions for the future health and social care system in East Kent; and
- A plan for meeting the 9 “Must Do’s” in the Planning Guidance

The Kent Integrated Dataset had expanded on the ‘Year of Care’ dataset and would shortly include data from South East Coast Ambulance Service.

The East Kent Strategy Board was operating several clinical task and finish groups to develop clinical models and 4 workshops were planned for mid-July 2016 to review the work of the groups. The work was clinically driven focusing on the best care for patients and was not about saving resources.

It was intended that public engagement would commence shortly and the voluntary sector was involved as part of the patient and public engagement group.

In response to a question concerning funding arrangements it was stated that this would be based on the quality of the plans and at this stage it was unclear what funding East Kent would be receiving.

A Kent and Medway STP steering group had also been established with the Chair of the East Kent Strategy Board and the Chief Executive Officer of East Kent Hospitals University Foundation Trust as the East Kent representatives.

RESOLVED: That the presentation be noted.

7 INTEGRATED COMMISSIONING BOARD DEVELOPMENT UPDATE

Ms M Farrow (Head of Leadership Support, Dover District Council) updated the Board on the progress in developing an Integrated Commissioning Board following the Development Day held in March 2016.

There were 3 proposed options for the Integrated Commissioning Board, each offering different levels of commissioning and budgetary responsibility. As part of determining the preferred option consideration would need to be given to the governance arrangements and role of Board members, whether the Integrated Commissioning Board would need to be a legal entity in its own right and focusing on outcomes and where most value could be added.

While some of the proposed changes required outside approvals it was noted that some changes could be delivered locally. It was noted that accountability would still remain with the respective accountable body. It was intended that the new arrangements would be in place for April 2017.

RESOLVED: That the updated be noted.

8 CHILDREN'S ARRANGEMENTS ACROSS KENT

This item had been withdrawn from the agenda.

9 LOCAL CHILDREN'S PARTNERSHIP GROUP UPDATE

Councillor J Hollingsbee (Shepway District Council) presented the update on the Local Children's Partnership Group (LCPG). A copy of the latest CYPP District Dashboards for Dover and Shepway were circulated to members of the Board.

The Board was advised that an updated set of Dashboards would be produced in the next few weeks which would contain revised figures for some of the data such as teenage conception as the existing data provided was for 2013. The Dashboard would be updated monthly by Kent County Council and this would be used to inform local priorities.

There would be 6 meetings of the LCPG per year, split between formal meetings and workshops. The issue of young peoples' representation on the LCPG was raised and the Board was advised that this was being investigated. It was noted that Shepway had a greater history of collaborative working with schools and this needed to be developed for Dover.

RESOLVED: That the update be noted.

10 WORKFORCE STRATEGY

Ms M Farrow (Head of Leadership Support, Dover District Council) advised that in the absence of Mr T Godfrey (Kent County Council) a report would be submitted to the Board at its next meeting.

Members were advised that the Workforce Strategy supported the Sustainability and Transformation Plans and brought NHS England and local priorities together.

RESOLVED: That the update be noted.

11 URGENT BUSINESS ITEMS

There were no items of urgent business.

The meeting ended at 4.36 pm.

To: South Kent Coast CCG Health and Wellbeing Board, 20 September 2016

Report: Local Workforce Action Board

From: Tristan Godfrey, STP Workforce Programme Manager (Kent and Medway), Health Education England

Summary

This report sets out how Health Education England, working across Kent, Surrey and Sussex (HEE KSS) will support and enable the delivery of the Kent and Medway Sustainability and Transformation Plan (STP) through a corresponding Local Workforce Action Board (LWAB).

1. Background

a) In May 2016, the Kent Health and Wellbeing Board set up a Workforce Task and Finish Group because workforce had been identified by all stakeholders as a priority area that needed addressing.

b) The Task and Finish Group met from October 2015 to March 2016 and involved representatives from health and social care. The Groups' final report was presented to the Kent Health and Wellbeing Board on 25 May 2016.

c) Five priority areas were identified and pursued in depth during the meetings. These are:

- existing and emerging gaps
- new models of care
- productivity
- recruitment and retention
- cross-cutting – 'the Brand of Kent';

d) An allocation of £200,000 from HEE KSS has been agreed with Kent County Council to support the implementation of these Task and Finish Group actions.

e) During the period of the review, the announcement about the Sustainability and Transformation Plans (STPs) was made. The STPs are intended to be the first step in a shift from planning on the basis of an individual organisation to planning as a system. The Workforce Task and Finish Group main finding is the need to make the same shift in workforce planning.

f) In a guidance letter published on the STPs (16 February), it was explained that 'Health Education England has agreed that they will establish a local Workforce Advisory Board to coordinate and support the workforce

requirements for each STP footprint.' Detail around what are now known as Local Workforce Action Boards (LWABs) began to come through subsequently. They are to be supported by the local teams of Health Education England. Health Education working across Kent, Surrey and Sussex (HEE KSS) is responsible for Kent and Medway.

g) Four specific projects have been identified nationally as appropriate for the LWAB to deliver to support the STPs across England:

- A comprehensive baseline of the NHS and social care workforce in the relevant labour market;
- A scenario based high level workforce strategy;
- A workforce transformation plan to support the STPs broader service ambitions;
- An action plan, which will include identifying investment need, to deliver the STP.

h) The LWAB for Kent and Medway is currently under development and will build in part on the work of the Workforce Task and Finish Group.

i) Each LWAB is to be chaired by the HEE Local Director and a senior leader from the STP footprint. These will be Philippa Spicer and Hazel Carpenter respectively. The Terms of Reference, including membership will be agreed with the STP Leadership Group.

j) An allocation of £1.3 million has been identified by HEE KSS to support the implementation of the LWAB action plan.

k) HEE KSS has additionally allocated funding through Medway Council, to support public health work across the whole of KSS, primarily to deliver Making Every Contact Count (MECC). This is being reviewed alongside the needs of the STPs with Public Health and therefore should be targeted where STPs require. This year's funding was £480k.

l) Funds have also been allocated to the Community Education Provider Networks (CEPNs). These funds are to provide a primary care focus, although the additional STP funding can be spent in a service area including additional funding into primary care.

CEPN Group	Funding
East Kent	£175,000
West Kent	£120,000
North Kent - DGS/Swale	£90,000
North Kent - Medway	£75,000
Total	**£460,000**

m) This is in addition to this year's workforce development monies distributed to the system, and the agreed spend on the Skills Development Strategy Programmes for 2016/17, which benefit the whole of Kent, Surrey and Sussex and will support the STPs.

n) HEE KSS has been working across the region through our Skills Development Strategy to develop new roles, up skill the existing workforce, improve the education, training and experience of trainees and students to enhance the quality of care and experience of our patients and population. HEE KSS is able to provide a range of support for the STPs. For example:

- Workforce Modelling
- Up-skilling and Leadership
- New Roles
- New Ways of Working
- Recruitment and Retention

3. Recommendations

The Health and Wellbeing Board is asked to note this report.

Lead officer contact

Tristan Godfrey
STP Workforce Programme Manager (Kent and Medway), Health Education England working across Kent, Surrey and Sussex
Tel: 03000 416157 Email: Tristan.godfrey@kent.gov.uk

Appendices

Workforce Task and Finish Group Report to Kent Health and Wellbeing Board

Background papers

None.

From: Workforce Task and Finish Group

To: Health and Wellbeing Board, 25 May 2016

Subject: Workforce Task and Finish Group: Final Report and Recommendations

Classification: Unrestricted.

Summary:

The Workforce Task and Finish Group held a succession of meetings between October 2015 and March 2016. This paper summarises the findings of the Group, including the five priority areas that have been identified to take forward along with an outline of the indicative action plan. It also sets out how it is proposed that this work will be consolidated and operationalized along with the support available to achieve this.

Recommendations:

The Health and Wellbeing Board is asked to:

1. Agree that the Workforce Task and Finish Group has completed its work but that the work continue in the form of a working group of the Integration Pioneer Steering Group and align with the Workforce Action Board to meet the needs of the STP;

2. Agree that the priority work areas for the group are to be those identified by the Task and Finish Group:

- ***existing and emerging gaps***
- ***new models of care***
- ***productivity***
- ***recruitment and retention***
- ***cross-cutting – 'the Brand of Kent'***;

3. Support the principle that the developing action plan recognises both the importance of activities at the local and county-wide levels.

1. Introduction

(a) The HWB agreed to establish the Workforce Task and Finish Group because ***workforce has been identified as a priority area that needed addressing***. Similarly, it was recognised that it was not an issue that could be tackled by each organisation on its own, though there were actions that were being and could be

taken locally. During the period of the review, the announcement about the Sustainability and Transformation Plans (STPs) has been made and these will be discussed at the same meeting as this paper. The recommendations of this report are intended to be ***supportive of STP implementation***.

(b) The Group identified five priority areas early and pursued these in depth in later meetings, hearing from a range of guest speakers. It was also able to draw on the expertise found in the HE KSS Kent Workforce Summit. All participants found these stimulating and the discussions began to produce a series of clearly identifiable actions to take forward.

(c) There was also agreement in the Group that addressing the workforce challenge was so fundamental that care was needed to ensure that decisive outcomes were achieved. The importance of determining the right actions to take, with the right people or organisations tasked with progressing them, is as important as ensuring the actions are supported by the whole system, with the lessons learnt shared in a timely fashion.

(d) The work of the Workforce Task and Finish Group as established by the Board at its meeting of 20 May 2016 has now concluded with the production of this report. However, a positive momentum for shifting to a more joined up strategic approach to workforce issues across Kent and Medway has been created and it is important that this is not lost. For this reason, the Group is requesting that the work be allowed to continue in a more appropriate forum. An indicative action plan which will be the initial focus of the continuing work is included in this report.

(e) Different staff groups and types take longer to develop than others. The medical workforce we will have in five years' time is already in the process of being trained. Bands 1-4 staff have a much shorter lead in time but will not be able to perform all the functions of other staff groups. In order to properly frame any analysis of the gap between the staff we will have available across Kent and Medway in 3-5 years' time and the staff we will need, there needs to be a clear vision of what health and care services will look like at this time. This way, we can work on identifying how to close the gap.

(f) The ***Sustainability and Transformation Plans*** (STPs) provide this opportunity. The STPs are intended to be the first step in a ***shift from planning on the basis of an individual organisation to planning as a system.*** The Workforce Task and Finish Group main finding is the need to make the same shift in workforce planning. Continuing the work of Group will go a long way to enabling the workforce element of the STPs to be supported and advanced.

(g) In a guidance letter published on the STPs (16 February), it was explained that 'Health Education England has agreed that they will establish ***a local Workforce Advisory Board*** to coordinate and support the workforce requirements for each STP footprint.' Detail around what are now known as Workforce Action

Boards (WABs) began to come through subsequently. In Kent, a lot of valuable preparatory work has already been undertaken by the current Workforce Task and Finish Group and involving Health Education England.

2. Context, risks and current situation

In both Health and Social Care there are significant workforce challenges. The figures below provide some examples of the context that the Health and Well-being board discussed from which the Workforce Task and Finish group was established:

- 10% of nursing posts (acute, community, primary care and mental health) in Kent are vacant.
- Of these vacant posts, 5% are filled by temporary staff, 2% by agency, and 3% remain unfilled.
- The hardest hit areas are Mental Health (20% vacant), Learning Disabilities (16%) and School Nursing (19%).
- There has been significant recruitment from overseas by NHS trusts in the last year, including from Portugal, Spain, Ireland, Italy, Philippines, and Poland. However there are now concerns that this supply is diminishing.
- Kent has a turnover rate of 27.7% for care workers in social care, slightly better than the national average but a high percentage (Skills for Care report, December 2015).
- Kent has a turnover rate of approximately 19% in care managers, slightly better than the average for the South East (Skills for Care report, December 2015).
- There are not enough school leavers to fill all the posts needed in Health and Social Care.
- GP recruitment and retention remains a challenge. The number of GPs aged 55 and over has doubled over the last 10 years and a BMA poll of 15,560 GPs in 2015 reported 34% intended to stop by 2020. 28% in the poll were seeking to reduce from full time working and 16% reported unmanageable levels of stress. A report into GP access to the Public Accounts Committee in March 2016 has shown a 3.5% rise in the number of consultations in primary care from 2004-05 to 2014-15 with only a 2% increase in staff over the same reporting period.
- Medical recruitment remains a challenge. Data from the annual Foundation F2 Career Destination Reports show an increase from 6.7% in 2013 to 9% in 2015 of doctors reporting they were planning to leave the UK for their next post and also a decline in the number of doctors planning to apply to GP and

Core Medical Training from 47.1% to 44.6%. To maintain GP workforce figures it is estimated 50% of all Foundation 2 doctors would need to enter GP specialty training. In General Practice Specialty Training there has been a 16.5% decrease in numbers of doctors applying from 2013-2015: whilst the number of programmes have increased and in 2014-15 overall 12% of training programmes were unfilled. HEE KSS has traditionally recruited fully in Round 1 this was not the case in 2015.

3. Key findings

(a) Ahead of the first meeting, a number of organisations represented on the Group completed a 'Key Themes' table that aimed at identifying areas of common concern and activity. One of the main lessons from this was the way ***short term planning has been heavily prioritised over the longer term***. Given the lead in time required for training professionals to new or developing roles, the need to approach workforce planning in a new way was clear from the beginning.

(b) Early discussions concentrated on identifying the following priority areas for further exploration:

- ***existing and emerging gaps***
- ***new models of care***
- ***productivity***
- ***recruitment and retention***
- ***cross-cutting – 'the Brand of Kent'***

(c) Relating to ***existing and emerging gaps***, the Group had presentations from HE KSS and from Social Care on the current workforce situation that helped identify key areas of concern. All other things being equal, there were some staff groups (such as adult nursing, to take just one example) where the supply would not meet the expected need.

(d) This connected with the discussion around ***New Models of Care*** and the drive towards more integration across the health and care sector. One of the challenges in workforce planning identified by the Group in relation to New Models of Care is the tension between needing to know what Models are being developed in order to develop the appropriately skilled staff. On the other hand, the choice of Models will be influenced by what workforce is available. This point applies more widely across the whole health and care sector and now needs to be seen in the broader context of the STPs.

(e) To resolve this, there needs to be a shift towards a ***focus on the skills required by a given workforce rather than how many of a particular staff group are needed***. The Group received a presentation on planned changes to the Public

Health Skills and Knowledge Framework being conducted by Public Health England[1]. There was a broad acceptance that the methodology used here could be used in areas other than for public health. For example, it could help identify overlapping skills between the social care and health workforce when looking to put together integrated teams or create the new job roles for the different New Care Models being developed across Kent.

(f) Another main area of focus was what could be learnt from other areas, in England and elsewhere. There was a lot of interest in the Group following a presentation on the workforce transformation work that had been carried out in ***Leeds***. Other models that had featured heavily in discussion or as part of other presentations that generated interested were ***the Buurtzorg model*** from the Netherlands, ***the Esther model*** from Sweden, along with integrated teams in Cornwall and work in London aimed at making the move between organisations streamlined.

(g) Given that both health and social care are facing significant financial challenges currently and will continue to do so over the next few years, and combined with the predicted gap between supply and demand for certain, one response is to consider how to achieve more with what we have. The Group were given a presentation on a piece of work on ***productivity*** using a systems dynamics approach which stimulated a discussion on how to make future demand modelling as robust as possible[2].

(h) The Group received feedback from a very successful East Kent Education Event and have heard that a similar one is being arranged in West Kent. Separately, HE KSS made available the resource of the next available quarterly Kent Workforce Summit. The timing was fortunate, and the Summit of 13 November was devoted to producing recommendations on ***recruitment, retention and 'the brand of Kent.'***

(i) One main theme in this area was the need to establish a more ***comprehensive career pathway*** setting out how working in one area can lead to progressing to a different and potentially more challenging area of work after a period of time. This applied across health and social care. Bands 1-4 were a particular priority here, these staff groups being seen as central to the longer term sustainability of the health and care workforce and the integration of the two services. There is also a shorter lead in time for Bands 1-4 staff groups compared to some others, which may be a consideration. A presentation on the HE KSS Career Progression Programme looking at this was well-regarded by the Group[3].

[1] Presented by Claire Cotter (Programme Manager, Workforce Development, Public Health England)

[2] Presentation given by Dr Mark Joy (Senior Lecturer School of Health Sciences, Faculty of Health & Medical Sciences, Surrey University)

[3] Given by Mike Bailey (Careers Progression Programme Manager, Health Education England working across Kent, Surrey and Sussex)

(j) The broader public health dimension was also discussed. The role of ***prevention*** and programmes like ***Making Every Contact Count*** were recognised as having a large part to play in making the system more sustainable. This connects with productivity in that resources spent on particular conditions would be released for other activities, but is also tied in with new models of care and delivering services in a different way.

(k) Another area considered was that of ***cultural barriers*** between health and social care, and between different areas within each sector (such as acute and primary care). There needs to be a greater awareness of how the world looks from the different perspectives, with measures taken to overcome this at sufficient scale to prepare the way for truly integrated teams.

4. A Workforce Framework for Health and Care

(a) Running through the work of the Group was the idea that there is a need to shift from planning as organisations to adopting a coordinated system wide approach. It was suggested that this could perhaps be organised in a similar format to the Surrey Health and Social Care Careers Collaborative (which formed part of the Bands 1-4 presentation, see Appendix 1). As will be discussed below, the exact shape needs to take into account broader policy changes in health and care.

(b) There is a lot of valuable work going on around workforce across Kent and Medway and this will continue. There is a workforce strand, for example, of the East Kent Strategy Board. The role of the proposed committee will be in part to disseminate knowledge of this, and similar, work and support it where possible. This will lead to a more efficient approach as work beginning in one area that has already been trialled somewhere else will be able to build on what has been done.

(c) There will also be work that is more usefully planned on a County-wide basis. This will include work that could help address the workforce challenges across Kent but which would need piloting or trialling in a particular geographical area or for a particular pathway of care. As set out in section 5 below, the Group could help identify the best fit for a trial or pilot.

(d) These different approaches need to continue alongside each other. There is no magic solution to the workforce challenge but the many actions that we can take need to be as effective as possible.

(e) In order to take the action plan forward, there has been discussion about how to carry on the work of the Group. The Workforce Task and Finish Group was established originally as a time-limited undertaking, but there was a shared desire not to lose the momentum created by the Group and follow up on the recommendations. In addition, the Group heard about the NHS England Pioneer

workforce support offer which is being developed[4]. It makes sense to bring this strand of work together with other workforce activities. Therefore, the recommendation of the Task and Finish Group is that it becomes a working group or committee of the Integration Pioneer Steering Group. It was felt the Integration Pioneer Steering Group was a pre-existing structure that would be well placed to continue the work. As a sub-committee itself of the HWB, the continuing work of this group around workforce would remain accountable to the Board.

(f) Following the Comprehensive Spending Review, the role and remit of Health Education England is in the process of change. If Kent and Medway wish to make a step-change towards a more strategic approach to workforce planning across health, social care and public health, there could be a way to align the changes to support each other. This idea has been given impetus by the announcement in the STP guidance that Health Education England will establish a local Workforce Action Board to support the workforce requirements of each STP footprint.

(g) The Kent HWB has already established strong links with the local team of Health Education England (covering Kent, Surrey and Sussex) and the Task and Finish Group has already carried out much of the preliminary work that other areas of the country will need to do prior to being able to fully capitalise on the support of the WAB. This provides an opportunity to make real progress in the workforce elements of the STPs.

(h) The prime intention behind establishing a workforce committee of the IPSG is to enable a clearer operational focus, with any relevant changes of membership and support. The role of the WAB and how it fits with other parts of the system has become clearer. To avoid duplication of effort and maintain this focus, the WAB and the committee proposed in this report could be one and the same. Because this will build on the work already undertaken in Kent, it may be that arrangements in Kent and Medway are different from those in other footprints across Kent, Surrey and Sussex.

(g) The local team of Health Education England are making available a £200,000 fund to support the further consolidation of the progress made by the Task and Finish Group and build on the positive relationship established with the Kent Health and Wellbeing Board. This fund is in addition to the regular work of Health Education England and the prime intention is to operationalize the emerging action plan as well as ensure workforce development is promoted across Kent in a strategic manner. Applications for funds will be welcomed from the successor group to the HWB Workforce Task and Finish Group/Workforce Action Board as well as from any commissioner or provider of health or social care services, or from an organisation involved in the education or training of the health and care workforce. This fund will be for the 2016/17 financial year and further details will be circulated shortly. It will be

[4] The Group heard from Hemlata Fletcher (Development Manager, Integrated Care Pioneer Support Team,New Models of Care Programme, NHS England)

jointly administered by the local team of Health Education England and the Strategy, Policy and Assurance Division at KCC.

5. Indicative Action Plan.

(a) The Task and Finish Group would not have been established last year without a consensus that workforce was an issue that required a system wide approach. This was, and remains, the case. The STPs are valuable in reinforcing the idea of place based planning across the system, of which workforce is a part. Action needs to be taken alongside the development of the STPs and steps taken to improve the workforce situation before they formally commence in October.

(b) To this end, the Task and Finish Group has begun to develop an indicative action plan. However, the Group was never intended to be the workforce planner for the wider Kent health and care economy. It had a strategic focus but following this report there needs to be a decisive shift of focus to the level of operational detail. As set out above, this is the main reason behind the recommendation to continue the work under the IPSG.

(c) This section of the report does not intend to prejudge any of the deliberations and decisions by the successor group but does indicate the direction of travel that the discussions have pointed in.

(d) As the context section sets out, there is a shortfall between workforce supply and demand. Several of the suggested actions below are short term and/or tactical, like undertaking education events, or much of the work around Bands 1-4. While these will help, they will not completely close the gap, and will address different parts of the workforce. Being a national issue as well as a local one, there will ultimately be a limit to how much of the overall gap can be closed but there are actions that will address part of the gap. Were the system as a whole able to take a strategic approach to workforce activity it could be possible to aggregate up the impact of individual actions to gauge how much of the gap remains. One approach would be to do this against the aggregate workforce plans of the providers.

(e) The STPs are intended to show how the Five Year Forward View will be delivered and therefore what the shape of service delivery will be like in the medium and longer term. From this point, we can collectively work backwards and map what actions need to be taken to reach this point, taking into account what is already being done.

(f) Although the examples in the action plan below (paragraph i) are quite specific, the Group did discuss in broader terms what the direction of travel could be for finding workforce solutions. For example:

- Assigning the quick wins to the right person or organisation(s) to action as soon as possible;

- Concentrate on the workforce needs of a particular pathway, for example COPD;
- The workforce requirements of an emerging new model of care;
- Addressing a priority residual gap identified from a mapping exercise.

(g) There is currently, and will continue to be, work addressing some of the workforce challenges being lead at a national level, like the 10-point plan for GPs. Other work will focus on factors around supply and demand specific to Kent, or where Kent is an outlier compared to other areas.

(h) The action plan below is indicative only but gives an idea of the kind of work that could be progressed under the five priority areas (there are overlaps between some of them).

(i) Indicative Action Plan:

- ***Existing and emerging gaps***
    - Research into retention. a. Analysis of exit interviews from providers to understand the reasons staff leave; b. Analysis of staff (number and type) moving between Kent and Medway based organisations compared to leaving Kent and Medway.
    - Development of a Workforce Framework for Health and Social Care.

- ***New models of care***
    - Programme of events, experience and training to overcome cultural barriers between different areas of work.
    - Pilot programme to adapt methodology of new Public Health Skills and Knowledge Framework.
    - Further exploration of lessons to be learned from Leeds Workforce Transformation.
    - Pilot programme to test the Buurtzorg Model within Kent.
    - Pilot programme to test the Esther Model within Kent.

- ***Productivity***
    - Pilot programme to test workforce productivity modelling with a focus on improving efficiency.
    - Follow through from the LGA/Newton Europe front end WHH work, and consider what it would mean if some of the clinical and professional requirements were shifted: a. Use Community Physicians instead of hospital in-patient consultants; b. In order to use the GP professional capacity to the full, increase Nurse Specialists' capacity; and c. In order to increase nursing capacity, look at which tasks could be delegated to HCAs and Care workers.

- ***recruitment and retention***

- Utilising skills of a. Health and Social Care Pre-Employment Programme Co-ordinator; b. Apprentice Health Ambassador.
- Careers events in West and East Kent.
- Production of definitive guidance on legal position for work experience placements.
- Bands 1-4 career progression. Development of idea of Surrey Hubs adapted for Kent.
- Professional Care Register: Care certificate for the social care sector workforce.

- ***cross-cutting – 'the Brand of Kent'***
  - Joint health and social care presence in schools promoting health and social care careers.
  - Development of one central online workforce hub.

(j) The emphasis above is on recommendations that can be taken forward locally and regionally. This does not preclude national policy or system issues being tackled in the most appropriate way.

(k) In all cases, care will be needed to correctly identify the right people or organisation(s) to take work forward to ensure that the work of the Group was consolidated and concrete achievements made. This is likely to be an early priority for the proposed working group.

6. Recommendations

Members of the Health and Wellbeing Board are asked to:

1. Agree that the Workforce Task and Finish Group has completed its work but that the work continue as a working group of the Integration Pioneer Steering Group and align with the Workforce Action Board to meet the needs of the STP;

2. Agree that the priority work areas for the group are to be those identified by the Task and Finish Group:

- ***existing and emerging gaps***
- ***new models of care***
- ***productivity***
- ***recruitment and retention***
- ***cross-cutting – 'the Brand of Kent'***

3. Support the principle that the developing action plan recognises both the importance of activities at the local and county-wide levels.

Background Documents

None.

Contact Details

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tristan.godfrey@kent.gov.uk

Appendix 1

Surrey Health & Social Care Careers Collaborative

'Through partnership working to meet the workforce challenges of the health and social care sectors in Surrey'

HEALTH SECTOR

INDEPENDENT/VOLUNTARY CARE SECTOR

SOCIAL CARE SECTOR INCLUDING COUNTY COUNCILS

SECTOR SKILLS COUNCILS

PARTNER ORGANISATIONS INC JCP

HIGHER EDUCATION AND FURTHER EDUCATION

PRIORITISATION

Identification, through hub, of workforce issue/need

Link into national, regional and local agendas

Labour market analysis

Establishment of Workforce 'Hotspot' Taskforce Meetings

PLANNING

Innovative solutions

Linked to workforce planning

Involvement of all relevant parties

Clarifying measurable outcomes

Tailored interventions

Building on best pratice

Identify roles and responsibilities

RESOURCING

Realistic costing of plan

Securing resource contribution from partner agencies

Identification of and bidding for relevant funding including ESF

Securing economies of scale

Link with HEI and FE

ENGAGEMENT

All partners in hub

Schools and colleges

NEETs

Career Advice Workshops

School & College Curriculum projects

Further development of health ambassador networks

Taster days

Pilots

PROCESSES

Robust transferable processes and procedures

Regional strategy development linked to national mandate and strategies

Outcomes based activity

Ensuring portability

Care Certificate

PRACTICE

Employment hub model

Employability schemes developed with JCP

Work experience

Traineeships

Pre-employment programmes

Apprenticeships

Apprenticeship Training Agency

Bank work or employment

PROGRESSION

Progress into employment

Career pathways

Vocational and academic routes

Assistant Practitioner

HCA development

Clinical and non-clinical roles

Succession planning and talent management

Access qualifications

MEASUREMENT

Robust monitoring and evaluation

Measuring outcomes

Data analysis

Assessment of return on investment

Wider implementation from pilots

Appendix 2 – The Work of the Group

(a) On 20 May 2015, the Board agreed to establish a task and finish group to look specifically at strategic workforce issues across the County. Workforce had been identified by the Board as one of the main barriers to implementing the necessary changes to the health and care system to make it both sustainable and deliver improvements to the quality and effectiveness of care. On the other hand, it was recognised that if the right actions could be identified, workforce could be changed to a major enabler.

(b) The original Membership of the Group as agreed is set out below:

- Susan Acott (CEO DGH) / Andy Brown (HR Director, DGH)
- Roberta Barker (Director of Workforce, MFT)
- Amanda Beer (Corporate Director Engagement, Organisation Design and Development, Kent County Council)
- Paul Bentley (Director of Workforce and Communications, MTW)
- Bob Bowes (Clinical Chair, NHS West Kent CCG)
- Chris Bown (CEO EKHUFT) / Sandra Le Blanc (HR Director, EKHUFT)
- Alison Burchell (Chief Operating Officer, Medway CCG)
- Hazel Carpenter (Accountable Officer, Thanet CCG)
- Helen Cunningham (Human Resources and Organisational Development Director, Medway Community Healthcare)
- Patricia Davies (Accountable Officer, DGS CCG and Swale CCG)
- Bethan Haskins (Chief Nurse, Ashford CCG and Canterbury and Coastal CCG)
- Tristan Godfrey (Policy and Relationships Adviser, KCC)
- Roger Gough (Chairman, Kent HWB)
- Steve Inett (Chief Executive, Healthwatch Kent) / Andrew Heyes
- Andrew Ireland (Corporate Director for Social Care, Health and Wellbeing)
- Paul Jones (Interim Director of Human Resources, KMPT)
- Nicky Lucey (Director of Nursing and Quality, KCHFT) / Margaret Daly (Deputy Director of HR and OD)
- Sarah Macdonald (Director of Commissioning, NHS England)
- Francesca Okosi (Director of Workforce Transformation, SECAmb)
- Mike Parks (Medical Secretary, Kent LMC) / Liz Mears (Clerk, Kent LMC)
- Andrew Scott-Clark (Director of Public Health, Kent County Council)
- Philippa Spicer (Managing Director, HE KSS)
- Robert Stewart (Chair, Integration Pioneer Steering Group)
- Ian Sutherland (Deputy Director, Children and Adults, Medway Council)
- Anne Tidmarsh – (Director Older People and Physical Disability, Kent County Council)

(c) In practice, there were changes to the individuals representing different organisations and a flexible approach to representation was adopted. In addition, it was agreed at an early meeting to extend an invitation to Ann Taylor from the Kent Integrated Care Alliance, who duly took part. Francesca Okosi (Director of Workforce Transformation, SECAmb) was elected as Chairman, and Anne Tidmarsh (Director

Older People and Physical Disability, KCC) as Vice-Chairman. Support was provided by officers from HE KSS and KCC.

(d) The Group originally arranged to meet six times between 13 October 2015 and 14 January 2016. However, it was agreed at the 6 January meeting that it was important to spend time getting right the shape of the final report and recommendations. A seventh meeting was arranged for 8 March 2016 to discuss the final report and recommendations.

Public Health England

Protecting and improving the nation's health

Dover

District

This profile was published on 6 September 2016

Health Profile 2016

Health in summary
The health of people in Dover is varied compared with the England average. About 21% (4,000) of children live in low income families. Life expectancy for both men and women is similar to the England average.

Health inequalities
Life expectancy is 6.9 years lower for men in the most deprived areas of Dover than in the least deprived areas.

Child health
In Year 6, 20.6% (206) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 27.6*. This represents 6 stays per year. Levels of teenage pregnancy, GCSE attainment and smoking at time of delivery are worse than the England average.

Adult health
The rate of alcohol-related harm hospital stays is 495*, better than the average for England. This represents 571 stays per year. The rate of self-harm hospital stays is 207.9*. This represents 227 stays per year. The rate of smoking related deaths is 300*, worse than the average for England. This represents 223 deaths per year. Estimated levels of adult smoking are worse than the England average. Rates of sexually transmitted infections and TB are better than average. The rate of violent crime is worse than average. The rate of statutory homelessness is better than average.

Local priorities
Priorities in Dover include improving life expectancy by preventing suicide and heart disease and reducing smoking prevalence, improving teenage pregnancy rates, and improving physical activity in children and adults. For more information see www.southkentcoastccg.nhs.uk or www.kmpho.nhs.uk

* rate per 100,000 population

Population: 113,000
Mid-2014 population estimate. Source: Office for National Statistics.

This profile gives a picture of people's health in Dover. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

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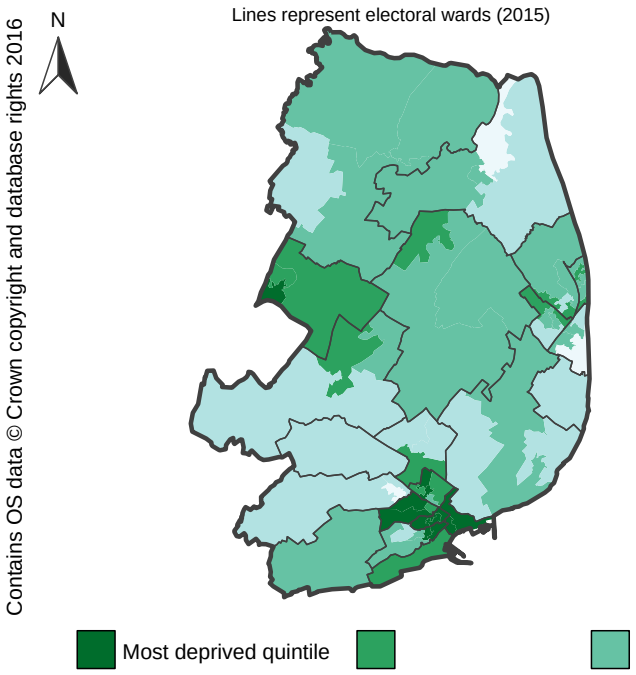
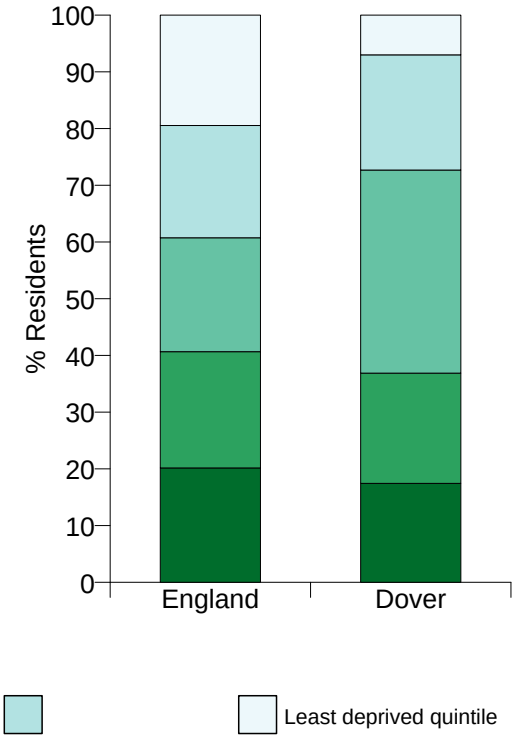
Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.



This chart shows the percentage of the population who live in areas at each level of deprivation.

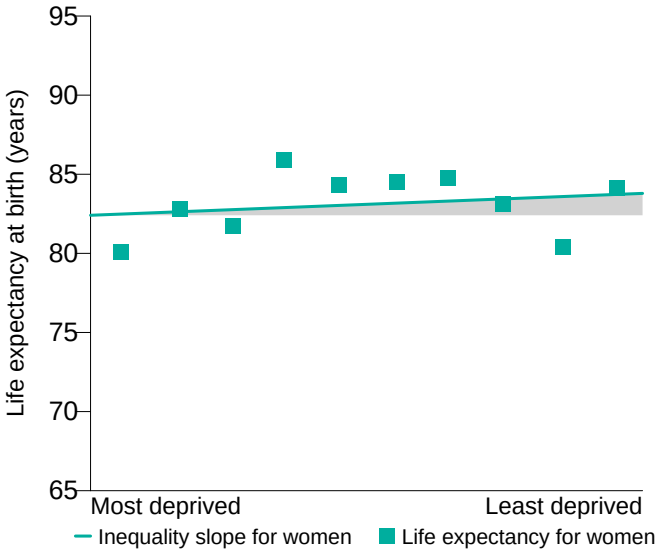


Life expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2012-2014. Each chart is divided into deciles (tenths) by deprivation (IMD2010), from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there was no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life expectancy gap for men: 6.9 years

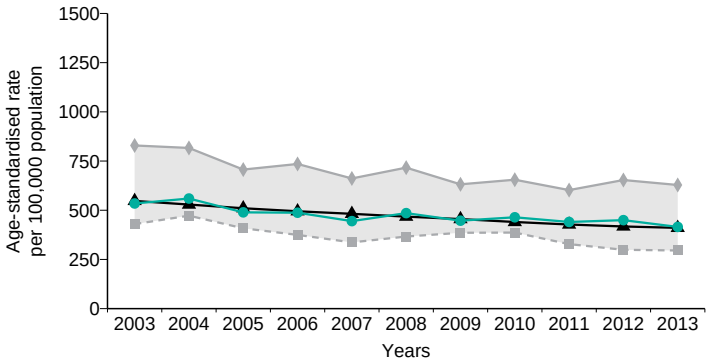
Life expectancy gap for women: 1.4 years



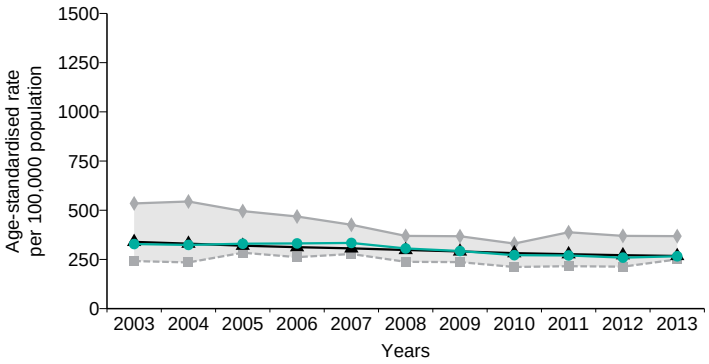
Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile (IMD2010) in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

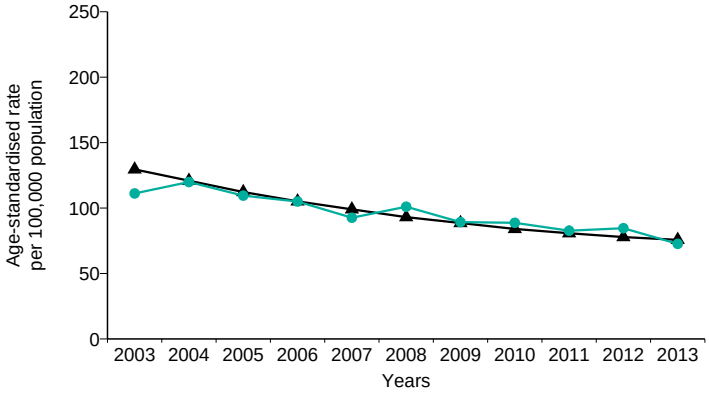
Early deaths from all causes: MEN



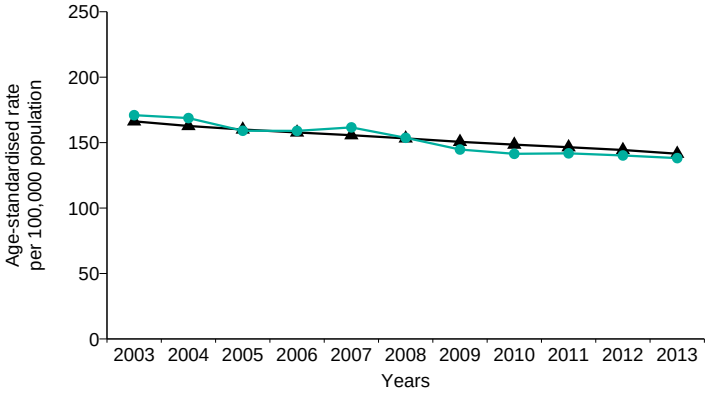
Early deaths from all causes: WOMEN



Early deaths from heart disease and stroke



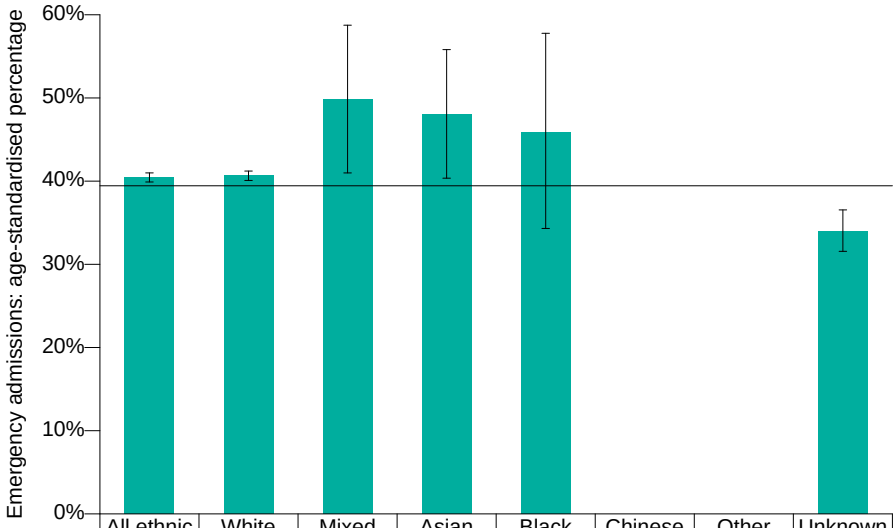
Early deaths from cancer



England average | Local average | Local least deprived | Local most deprived | Local inequality

Health inequalities: ethnicity

Percentage of hospital admissions that were emergencies, by ethnic group, 2014/15



This chart shows the percentage of hospital admissions for each ethnic group that were emergencies, rather than planned. A higher percentage of emergency admissions may be caused by higher levels of urgent need for hospital services or lower use of services in the community. Comparing percentages for each ethnic group may help identify inequalities.

Dover

95% confidence interval

England average (all ethnic groups)

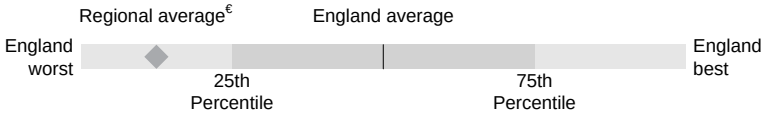
Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
12,576	11,868	60	74	29	-	-	461	Local number of emergency admissions
40.4	40.6	49.9	48.0	45.8	-	-	34.0	Local value %
39.4	39.9	38.8	44.0	43.1	35.9	44.9	30.9	England value %

Health summary for Dover

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



Domain		Indicator	Period	Local No total count	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1	Deprivation score (IMD 2015) #	2015	n/a	21.6	21.8	42.0		5.0
	2	Children in low income families (under 16s)	2013	4,005	20.9	18.6	34.4		5.9
	3	Statutory homelessness†	2014/15	8	0.2	0.9	7.5		0.1
	4	GCSEs achieved†	2014/15	642	53.3	57.3	41.5		76.4
	5	Violent crime (violence offences)	2014/15	1,979	17.6	13.5	31.7		3.4
	6	Long term unemployment	2015	342	5.1	4.6	15.7		0.5
Children's and young people's health	7	Smoking status at time of delivery	2014/15	166	15.0	11.4	27.2		2.1
	8	Breastfeeding initiation	2014/15	731	x[1]	74.3	47.2		92.9
	9	Obese children (Year 6)	2014/15	206	20.6	19.1	27.8		9.2
	10	Alcohol-specific hospital stays (under 18)	2012/13 - 14/15	19	27.6	36.6	104.4		10.2
	11	Under 18 conceptions	2014	68	32.7	22.8	43.0		5.2
Adults' health and lifestyle	12	Smoking prevalence in adults†	2015	n/a	29.7	16.9	32.3		7.5
	13	Percentage of physically active adults	2015	n/a	56.4	57.0	44.8		69.8
	14	Excess weight in adults	2012 - 14	n/a	64.0	64.6	74.8		46.0
Disease and poor health	15	Cancer diagnosed at early stage #	2014	258	44.3	50.7	36.3		67.2
	16	Hospital stays for self-harm	2014/15	227	207.9	191.4	629.9		58.9
	17	Hospital stays for alcohol-related harm	2014/15	571	495	641	1223		374
	18	Recorded diabetes	2014/15	6,251	7.1	6.4	9.2		3.3
	19	Incidence of TB	2012 - 14	12	3.6	13.5	100.0		0.0
	20	New sexually transmitted infections (STI)	2015	325	470	815	3263		191
	21	Hip fractures in people aged 65 and over	2014/15	168	661	571	745		361
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2012 - 14	n/a	79.4	79.5	74.7		83.3
	23	Life expectancy at birth (Female)	2012 - 14	n/a	82.8	83.2	79.8		86.7
	24	Infant mortality†	2012 - 14	12	3.4	4.0	7.2		0.6
	25	Killed and seriously injured on roads	2012 - 14	117	34.7	39.3	119.4		9.9
	26	Suicide rate†	2012 - 14	37	12.3	10.0			
	27	Deaths from drug misuse #	2012 - 14	7	x[2]	3.4			
	28	Smoking related deaths	2012 - 14	670	300.4	274.8	458.1		152.9
	29	Under 75 mortality rate: cardiovascular	2012 - 14	239	72.7	75.7	135.0		39.3
	30	Under 75 mortality rate: cancer	2012 - 14	458	138.2	141.5	195.6		102.9
	31	Excess winter deaths	Aug 2011 - Jul 2014	159	13.7	15.6	31.0		2.3

Indicator notes

1 Index of Multiple Deprivation (IMD) 2015 2 % children (under 16) in low income families 3 Eligible homeless people not in priority need, crude rate per 1,000 households 4 5 A*-C including English & Maths, % pupils at end of key stage 4 resident in local authority 5 Recorded violence against the person crimes, crude rate per 1,000 population 6 Crude rate per 1,000 population aged 16-64 7 % of women who smoke at time of delivery 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery 9 % school children in Year 6 (age 10-11) 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 12 Current smokers, Annual Population Survey (APS) 13 % adults achieving at least 150 mins physical activity per week 14 % adults classified as overweight or obese, Active People Survey 15 Experimental statistics - % of cancers diagnosed at stage 1 or 2 16 Directly age sex standardised rate per 100,000 population 17 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population 18 % people on GP registers with a recorded diagnosis of diabetes 19 Crude rate per 100,000 population 20 All new diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population 21 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over 22, 23 The average number of years a person would expect to live based on contemporary mortality rates 24 Rate of deaths in infants aged <1 year per 1,000 live births 25 Rate per 100,000 population 26 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 10+) 27 Directly age standardised rate per 100,000 population 28 Directly age standardised rate per 100,000 population aged 35 and over 29 Directly age standardised rate per 100,000 population aged under 75 30 Directly age standardised rate per 100,000 population aged under 75 31 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths (three years)

† Indicator has had methodological changes so is not directly comparable with previously released values. € "Regional" refers to the former government regions.
# New indicator for Health Profiles 2016. x[1] Value not published for data quality reasons x[2] Value cannot be calculated as number of cases is too small

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

Public Health England

Protecting and improving the nation's health

Shepway

District

This profile was published on 6 September 2016

Health Profile 2016

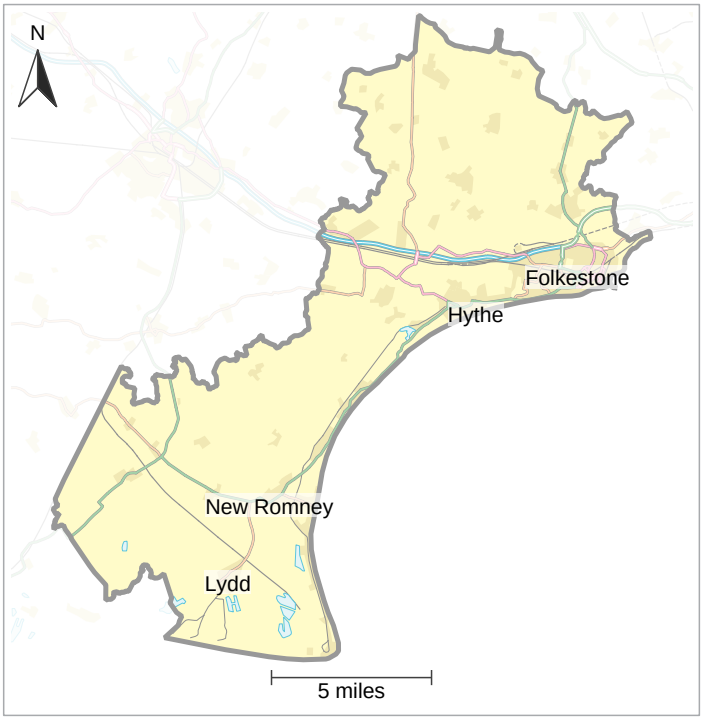
Health in summary
The health of people in Shepway is varied compared with the England average. About 22% (4,000) of children live in low income families. Life expectancy for both men and women is similar to the England average.

Health inequalities
Life expectancy is 5.5 years lower for men in the most deprived areas of Shepway than in the least deprived areas.

Child health
In Year 6, 19.1% (192) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 38.6*. This represents 8 stays per year. Levels of GCSE attainment, breastfeeding initiation and smoking at time of delivery are worse than the England average.

Adult health
The rate of alcohol-related harm hospital stays is 543*, better than the average for England. This represents 607 stays per year. The rate of self-harm hospital stays is 232.7*, worse than the average for England. This represents 237 stays per year. The rate of smoking related deaths is 285*. This represents 214 deaths per year. The rate of sexually transmitted infections is better than average. Rates of violent crime and long term unemployment are worse than average. The rate of statutory homelessness is better than average.

Local priorities
Priorities in Shepway include physically active children and adults, smoking in pregnancy, and teenage pregnancy. For more information see www.southkentcoastccg.nhs.uk or www.kmpho.nhs.uk



Population: 109,000
Mid-2014 population estimate. Source: Office for National Statistics.

This profile gives a picture of people's health in Shepway. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

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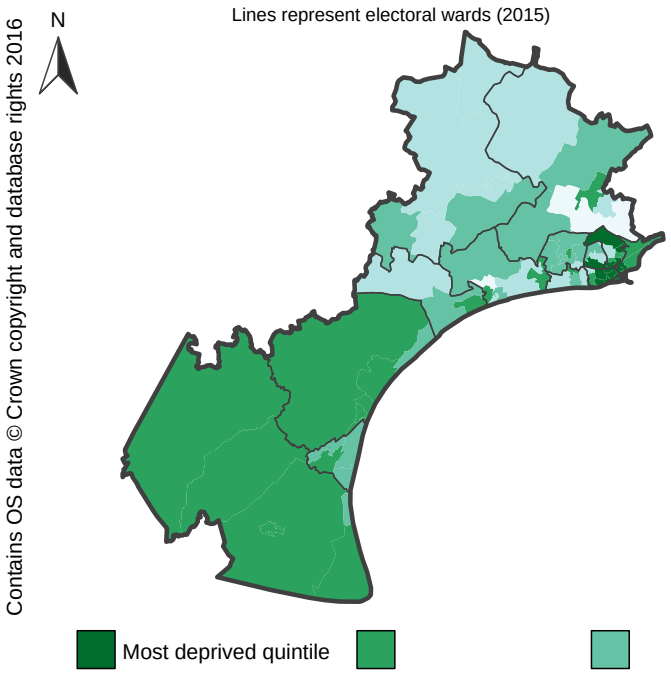
Follow @PHE_uk on Twitter

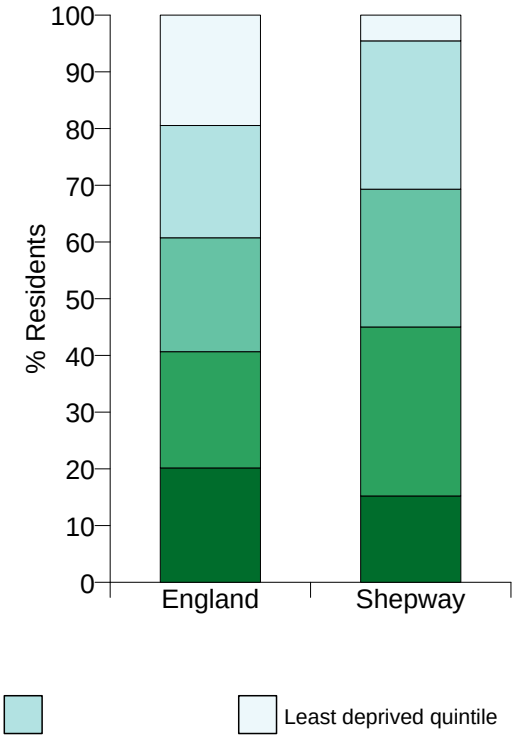
* rate per 100,000 population

Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.



This chart shows the percentage of the population who live in areas at each level of deprivation.

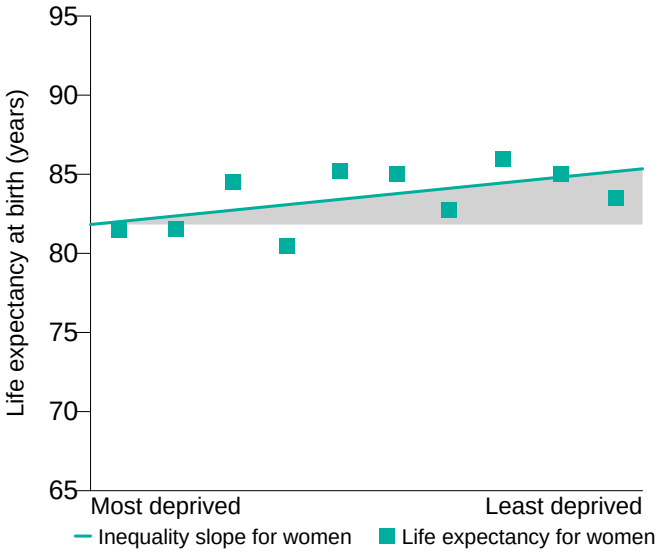


Life expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2012-2014. Each chart is divided into deciles (tenths) by deprivation (IMD2010), from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there was no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life expectancy gap for men: 5.5 years

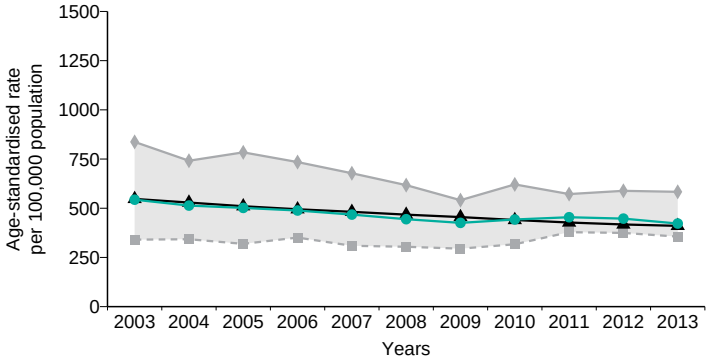
Life expectancy gap for women: 3.5 years



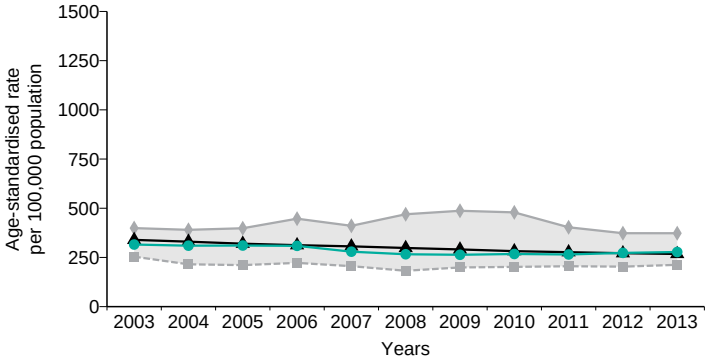
Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile (IMD2010) in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

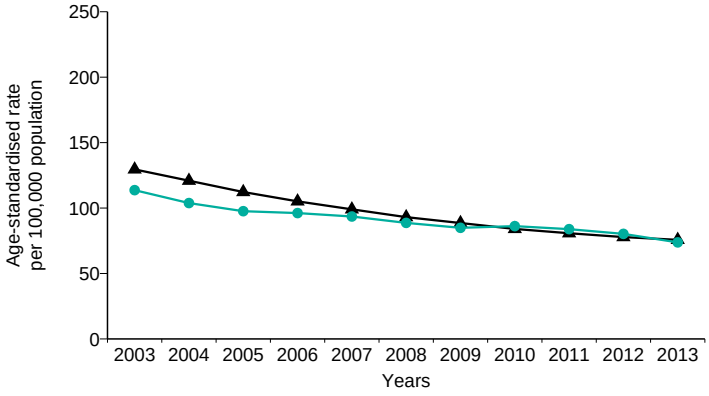
Early deaths from all causes: MEN



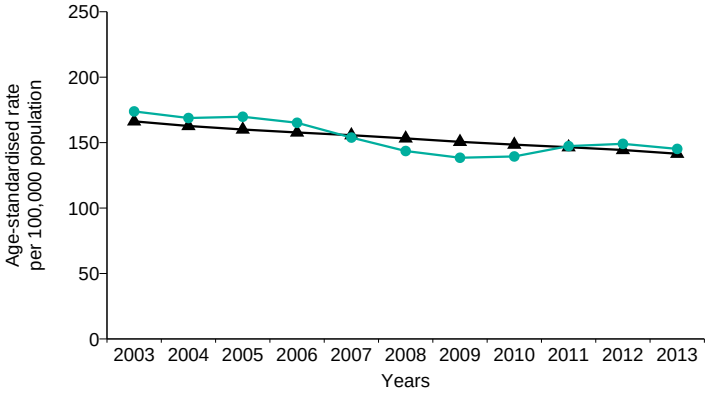
Early deaths from all causes: WOMEN

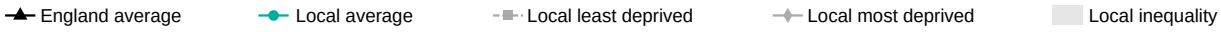


Early deaths from heart disease and stroke



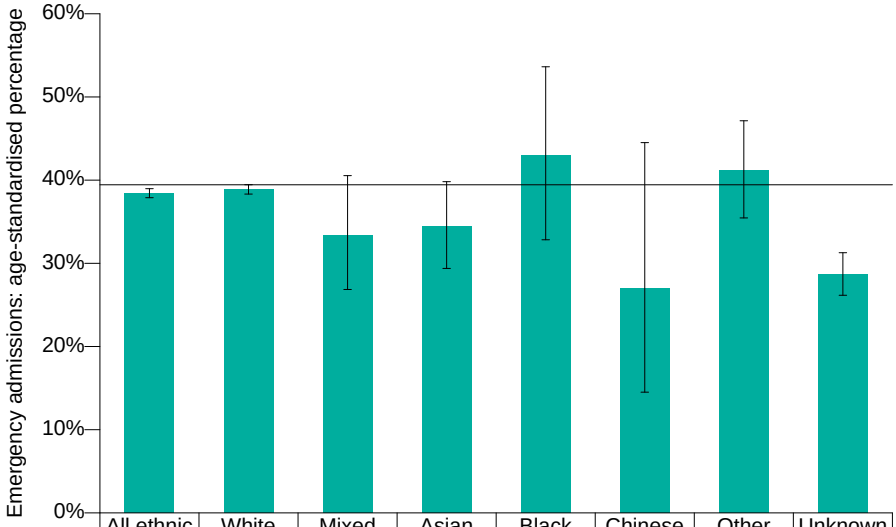
Early deaths from cancer





Health inequalities: ethnicity

Percentage of hospital admissions that were emergencies, by ethnic group, 2014/15



This chart shows the percentage of hospital admissions for each ethnic group that were emergencies, rather than planned. A higher percentage of emergency admissions may be caused by higher levels of urgent need for hospital services or lower use of services in the community. Comparing percentages for each ethnic group may help identify inequalities.

Shepway

95% confidence interval

England average (all ethnic groups)

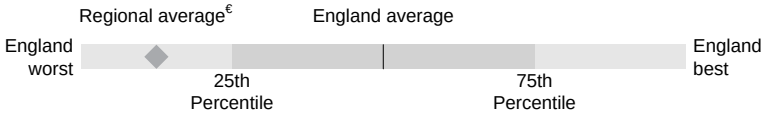
Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
11,925	11,265	60	106	34	8	110	342	Local number of emergency admissions
38.4	38.9	33.3	34.4	42.9	27.0	41.2	28.6	Local value %
39.4	39.9	38.8	44.0	43.1	35.9	44.9	30.9	England value %

Health summary for Shepway

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



Domain		Indicator	Period	Local No total count	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1	Deprivation score (IMD 2015) #	2015	n/a	22.8	21.8	42.0		5.0
	2	Children in low income families (under 16s)	2013	4,010	21.5	18.6	34.4		5.9
	3	Statutory homelessness†	2014/15	18	0.4	0.9	7.5		0.1
	4	GCSEs achieved†	2014/15	598	52.1	57.3	41.5		76.4
	5	Violent crime (violence offences)	2014/15	1,923	17.7	13.5	31.7		3.4
	6	Long term unemployment	2015	363	5.6	4.6	15.7		0.5
Children's and young people's health	7	Smoking status at time of delivery	2014/15	162	15.8	11.4	27.2		2.1
	8	Breastfeeding initiation	2014/15	756	70.7	74.3	47.2		92.9
	9	Obese children (Year 6)	2014/15	192	19.1	19.1	27.8		9.2
	10	Alcohol-specific hospital stays (under 18)	2012/13 - 14/15	25	38.6	36.6	104.4		10.2
	11	Under 18 conceptions	2014	45	23.9	22.8	43.0		5.2
Adults' health and lifestyle	12	Smoking prevalence in adults†	2015	n/a	15.7	16.9	32.3		7.5
	13	Percentage of physically active adults	2015	n/a	58.1	57.0	44.8		69.8
	14	Excess weight in adults	2012 - 14	n/a	66.2	64.6	74.8		46.0
Disease and poor health	15	Cancer diagnosed at early stage #	2014	242	45.1	50.7	36.3		67.2
	16	Hospital stays for self-harm	2014/15	237	232.7	191.4	629.9		58.9
	17	Hospital stays for alcohol-related harm	2014/15	607	543	641	1223		374
	18	Recorded diabetes	2014/15	6,467	7.0	6.4	9.2		3.3
	19	Incidence of TB	2012 - 14	32	9.8	13.5	100.0		0.0
	20	New sexually transmitted infections (STI)	2015	350	526	815	3263		191
	21	Hip fractures in people aged 65 and over	2014/15	157	573	571	745		361
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2012 - 14	n/a	79.7	79.5	74.7		83.3
	23	Life expectancy at birth (Female)	2012 - 14	n/a	83.4	83.2	79.8		86.7
	24	Infant mortality†	2012 - 14	12	3.5	4.0	7.2		0.6
	25	Killed and seriously injured on roads	2012 - 14	137	42.0	39.3	119.4		9.9
	26	Suicide rate†	2012 - 14	36	12.4	10.0			
	27	Deaths from drug misuse #	2012 - 14	11	x^2	3.4			
	28	Smoking related deaths	2012 - 14	642	284.7	274.8	458.1		152.9
	29	Under 75 mortality rate: cardiovascular	2012 - 14	234	73.8	75.7	135.0		39.3
	30	Under 75 mortality rate: cancer	2012 - 14	469	145.2	141.5	195.6		102.9
	31	Excess winter deaths	Aug 2011 - Jul 2014	169	14.8	15.6	31.0		2.3

Indicator notes

1 Index of Multiple Deprivation (IMD) 2015 2 % children (under 16) in low income families 3 Eligible homeless people not in priority need, crude rate per 1,000 households 4 5 A*-C including English & Maths, % pupils at end of key stage 4 resident in local authority 5 Recorded violence against the person crimes, crude rate per 1,000 population 6 Crude rate per 1,000 population aged 16-64 7 % of women who smoke at time of delivery 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery 9 % school children in Year 6 (age 10-11) 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 12 Current smokers, Annual Population Survey (APS) 13 % adults achieving at least 150 mins physical activity per week 14 % adults classified as overweight or obese, Active People Survey 15 Experimental statistics - % of cancers diagnosed at stage 1 or 2 16 Directly age sex standardised rate per 100,000 population 17 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population 18 % people on GP registers with a recorded diagnosis of diabetes 19 Crude rate per 100,000 population 20 All new diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population 21 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over 22, 23 The average number of years a person would expect to live based on contemporary mortality rates 24 Rate of deaths in infants aged <1 year per 1,000 live births 25 Rate per 100,000 population 26 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 10+) 27 Directly age standardised rate per 100,000 population 28 Directly age standardised rate per 100,000 population aged 35 and over 29 Directly age standardised rate per 100,000 population aged under 75 30 Directly age standardised rate per 100,000 population aged under 75 31 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths (three years)

† Indicator has had methodological changes so is not directly comparable with previously released values. € "Regional" refers to the former government regions.
# New indicator for Health Profiles 2016. x^2 Value cannot be calculated as number of cases is too small

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

From: Jessica Mookherjee, Consultant in Public Health – Kent County Council and South Kent Coast

To: South Kent Coast Health and Well Being Board

Date: September 12th 2016

Title: Closing the Gap in Health Inequalities in South Kent Coast

Authors: Jessica Mookherjee, Consultant in Public Health. Ivan Rudd, Specialist in Public Health.

Introduction

1.1 The Kent Health Inequalities Strategy – Mind the Gap (2013-15) brought the wider determinants of health to the attention of local Health and Well Being Boards. A South Kent Coast Health Inequalities Strategy, "Right Treatment, Right Care, Right Time" was published in 2013/4. However, across Kent Health Inequalities have been flat-lining at best and, in places, getting worse.

1.2 The Director of Public Health's Annual Public Health Report for 2015 concentrated on Kent's Health Inequalities. He was clear that in order to narrow the health inequalities across Kent concentration was needed on those areas where there was greatest deprivation.

1.3 Over a range of health indicators, Kent usually has better then the England average e.g. life expectancy and mortality rates. However, this is not the case for Dover and Shepway Districts. Deprivation statistics in South Kent Coast Clinical Commissioning Group area are higher than the Kent average and the England average, with generally worse health outcomes. Across Kent most people die of Cancer, but the most significant causes of death (in both men and women) in South Kent Coast CCG and Dover and Shepway districts are cardiovascular disease, respiratory disease and Gastro-Intestinal disease as well as Cancer. In the main these diseases are preventable through earlier detection, behavioural modification and optimal risk management. However, it is understandable that people who live with more economic hardship often have to make hard and stressful decisions in order to survive. Therefore, this report supports prioritising the people in the areas of greatest deprivation to improve their health outcomes. This will be done taking a three-fold approach, equity in health services and proactive care, community engagement and support and place shaping and population based interventions.

2. Health Inequalities in South Kent Coast

2.1 The data presented in the report showed that people in the most deprived communities in Kent had a statistically significant chance of dying at far greater rates then the rest of the Kent population. The report cuts the smaller geographical areas (or Lower Level Super Output Areas) into groups of ten (deciles). The 10th (most) deprived decile is where the people with highest rates of premature mortality live. The people living in these areas also suffer higher rates of diseases and behaviours that contribute to early death. The difference between the most affluent deciles and the poorest deciles is called the Health Inequalities GAP. The challenge across Kent, is to reduce this GAP.

2.2 There are 88 Lower Level Super Output Areas (LLSOAS) that feature in the most deprived decile for deprivation across Kent. The Majority of these economically poorer areas are in East Kent. Out of these 88, there are **19** LLSOAS in South Kent Coast. There are 11 in Dover (six wards) and 8 in Shepway (three wards). The wards and lower level super output areas are shown in Table 1.

2.3 Attached are two papers *The Mind the Gap: Health Inequalities Action Plan for Kent Analytical Report 2016*[1] and a more localised specific report for South Kent Coast CCG[2]. This report provides an overview of inequalities in Kent since Kent's 2012 Strategy 'Mind the Gap'.

Inequalities in South Kent Coast Clinical Commissioning Group area.

Table 1. Summary of the of the most deprived deciles for SCK CCG (Dover and Shepway)

District Council	CCG Hub	Ward Name	2011 LSOA Name	Kent LSOA Rank
Dover	**Dover**	Aylesham	Dover 006C	88
		Buckland	Dover 011D	48
		Buckland	Dover 011A	72
		Castle	Dover 012F	32
		Maxton, Elms Vale and Priory	Dover 013B	37
		Maxton, Elms Vale and Priory	Dover 013A	70
		St Radigunds	Dover 011F	24
		Tower Hamlets	Dover 012D	58
		Tower Hamlets	Dover 013D	71
		Tower Hamlets	Dover 011H	81
		Town and Pier	Dover 013E	74
Shepway	**Folkestone**	East Folkestone	Shepway 003C	26
		East Folkestone	Shepway 003A	83
		East Folkestone	Shepway 004B	86
		Folkestone Harbour	Shepway 014A	12
		Folkestone Harbour	Shepway 004E	68
		Folkestone Central	Shepway 014B	23
		Folkestone Central	Shepway 014D	49
		Folkestone Central	Shepway 014C	53

Source: KPHO 2016

3. Taking Action

The new Kent Health Inequalities Strategy for 2016 onwards wants local Health & Well Being Boards to prioritise these most deprived areas in order to tackle the health inequalities GAP. There are three key ways this can be done:

1. **Service Approach**: Where **preventative**, **assertive and proactive health care** is possible (e.g. the key killers and illness in these areas are lung cancer, alcohol related illness, COPD and heart disease) these health related interventions such as routine screening, primary care follow up, assertive reach and self care - should be carried out. A detailed health inequalities strategy for the CCG will be devised and represented to Health and Well Being Board in November 2016. Delivery will be via three key work strands of the CCG (and health partnerships). These are Prevention and Self Care Plan, The Primary Care Strategy and the Organisational Development and Work Force Strategy. These strategies will ensure there is a

[1] http://www.kpho.org.uk/__data/assets/pdf_file/0011/58835/Mind-the-Gap-Analytical-Report-D2.pdf

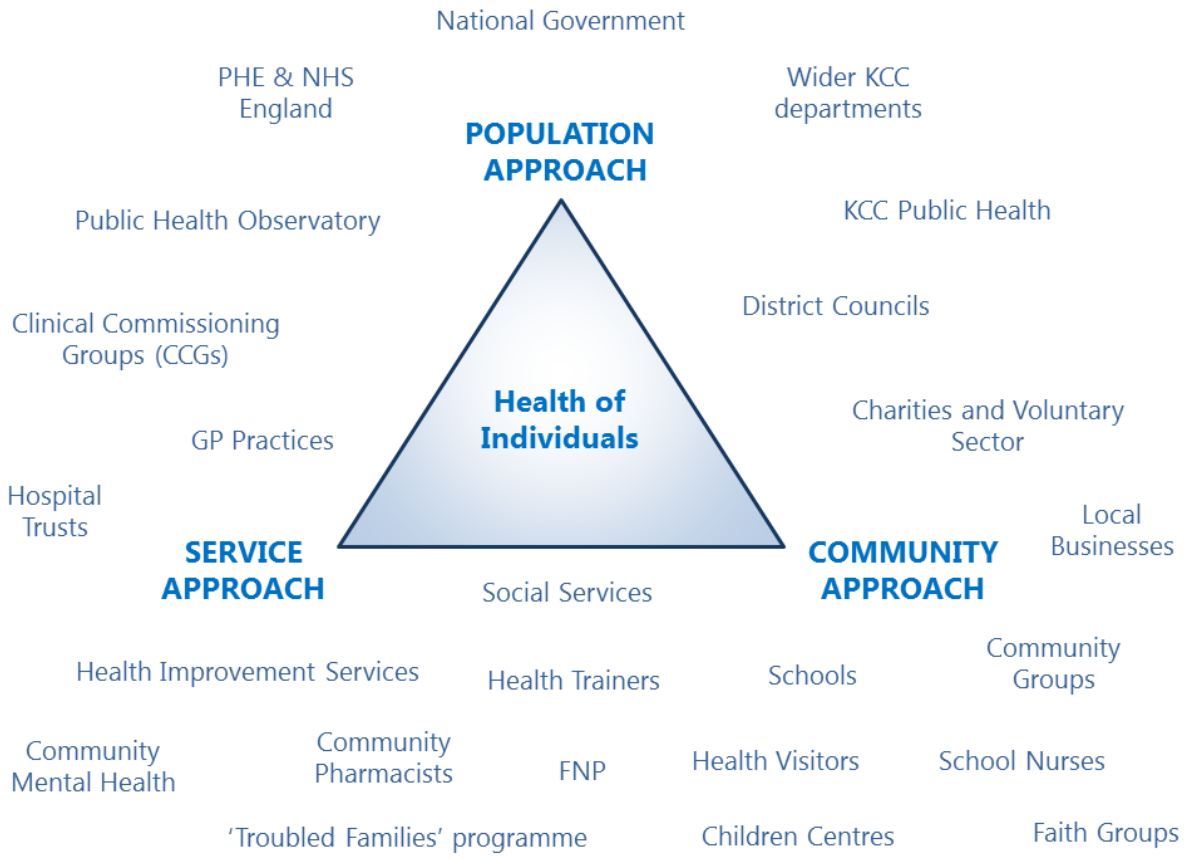
focus on the right care for those with drug and alcohol problems, smoking related illness (e.g. lung cancer) and heart disease.

2. **Community Approach: Area based approaches including community and asset development** will take place in each of the communities that are identified as priority. For this to take place the local public health teams will co-ordinate some local community research and information gathering on the communities in question. It is clear that District Councils and local members have a wealth of information. Once this is collated and the communities are identified, engagement with the communities is vital – and the health and Well Being Board members are asked to advise on how best to progress this for Dover and Shepway. Pooling of resources from all partners such as engagement workers, communications teams, care navigators and local people will be vital. Once the communities have been identified and engaged – it is hoped that local community health plans will drawn up to address people's concerns.
3. **Population Approach: Place Shaping and Preventative Plans** will be brought together The Health and Well Being Board are asked to advise on how the district plans can be shaped to target the vulnerable communities e.g. links with planning and licencing, the workforce and economy and leading on a plan to reduce obesity, smoking and alcohol harm.

4. Conclusion

The South Kent Coast Health and Well Being Board is asked to

a/ Note and comment on the Health Inequalities papers from KCC – in particular reference to the new locality data profiles published by PHE.
b/ Comment on the feasibility and approach to tackling the most economically vulnerable communities first and gathering more information on the communities in question.
c/ Advise the public health team on resources needed to conduct the community research – i.e. one meeting, or small task and finish group?


National Government
PHE & NHS England
Wider KCC departments
POPULATION APPROACH
Public Health Observatory
KCC Public Health
Clinical Commissioning Groups (CCGs)
District Councils
Health of Individuals
GP Practices
Charities and Voluntary Sector
Hospital Trusts
Local Businesses
SERVICE APPROACH
COMMUNITY APPROACH
Social Services
Health Improvement Services
Health Trainers
Schools
Community Groups
Community Mental Health
Community Pharmacists
FNP
Health Visitors
School Nurses
'Troubled Families' programme
Children Centres
Faith Groups

KENT PUBLIC HEALTH OBSERVATORY

Mind The Gap: Health Inequalities Action Plan for Kent

Analytical Report

June 2016

Produced by

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Many thanks for Professor Chris Bentley for his advice and guidance

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Version: 1.2
Last Updated: 14th June 2016

Contents

1. Executive summary

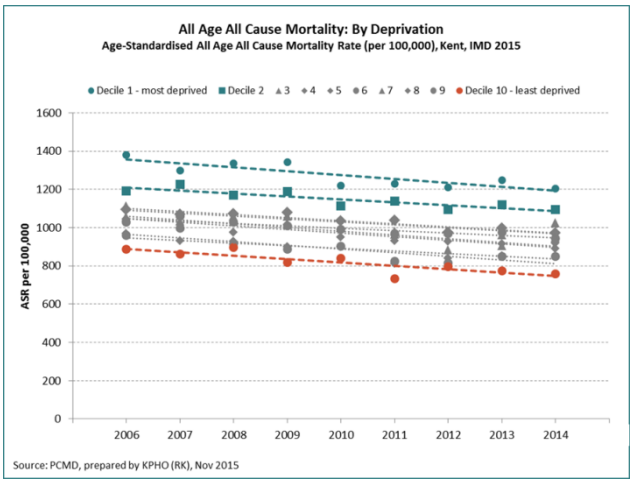
1.1 Introduction

This analysis was conducted to help inform the 2015 Public Health Annual Report and the forthcoming Mind the Gap: Health Inequalities Action Plan for Kent 2016. The analysis seeks to provide greater understanding of the true nature of the health inequalities in Kent.

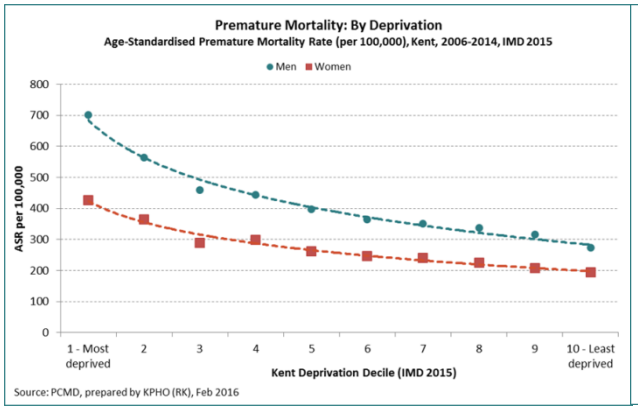
1.2 Key findings

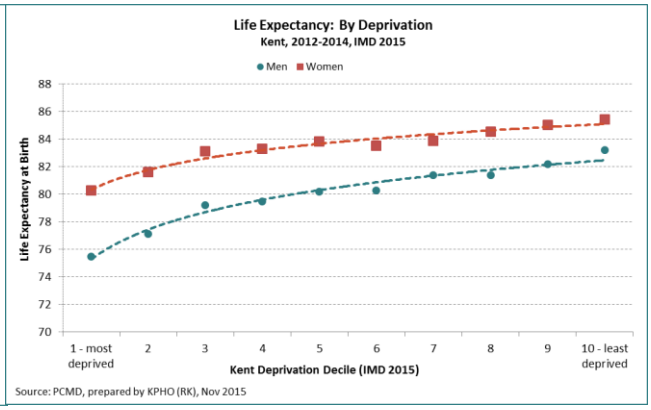
1.2.1 Inequalities in health outcomes

Whilst mortality rates in Kent have been falling over the last decade, the 'gap' in mortality rates between the most deprived and least deprived persists. This gap is particularly large for the most deprived deciles.



The most deprived populations have disproportionately worse premature mortality rates and life expectancy. This is demonstrated by the non-linear nature of the relationship between these high level health outcomes and deprivation.





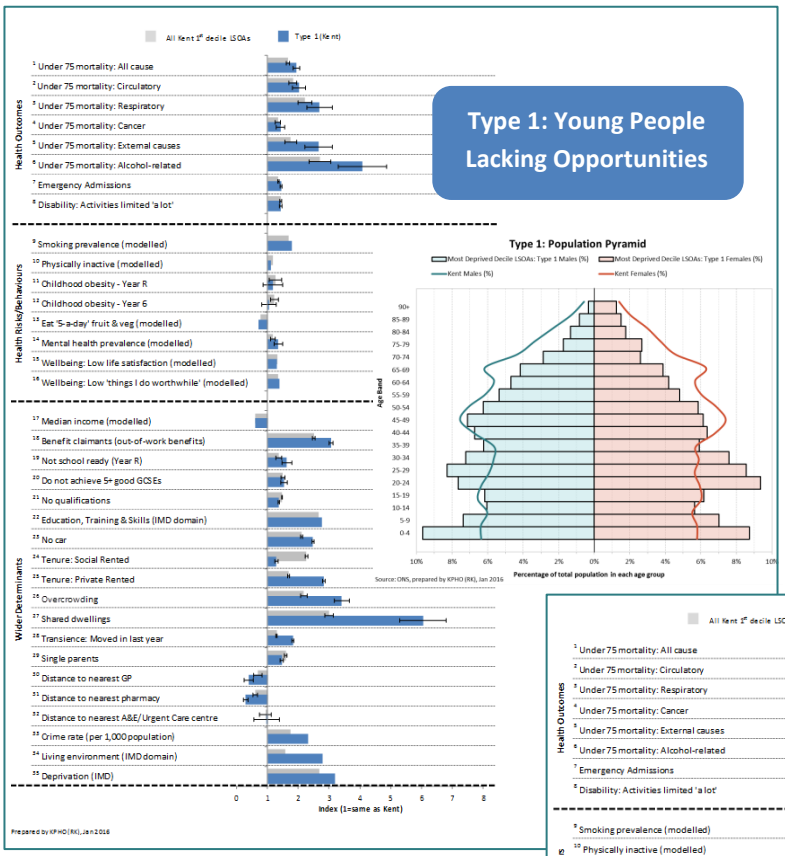
There are also inequalities in the causes of premature mortality. In the more deprived deciles, an increased proportion of the deaths are caused by cardiovascular, respiratory and GI disease.

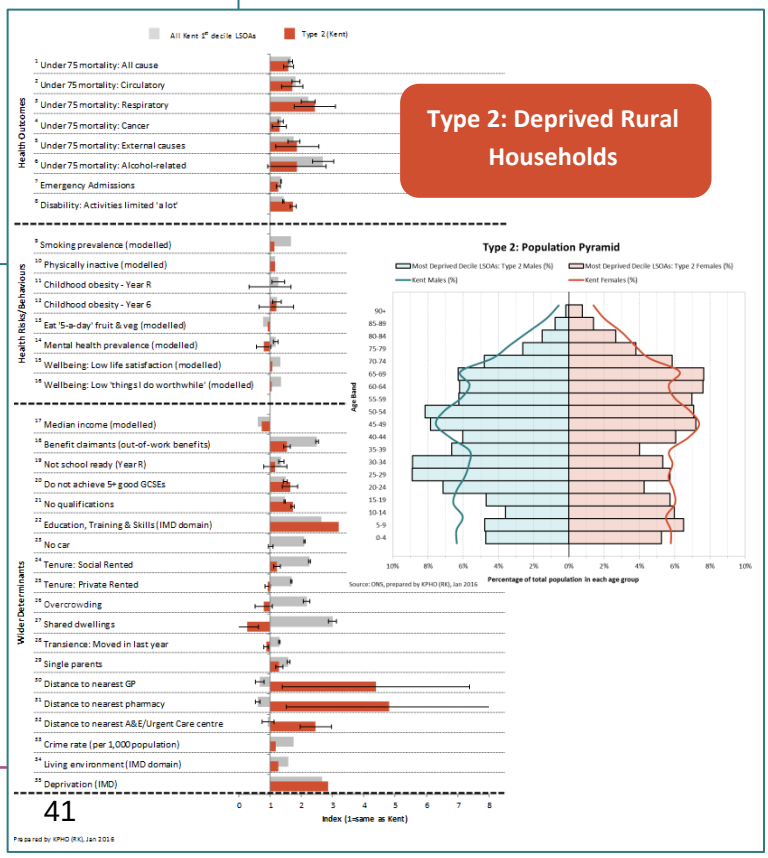
1.2.2 Inequalities in the wider determinants of health

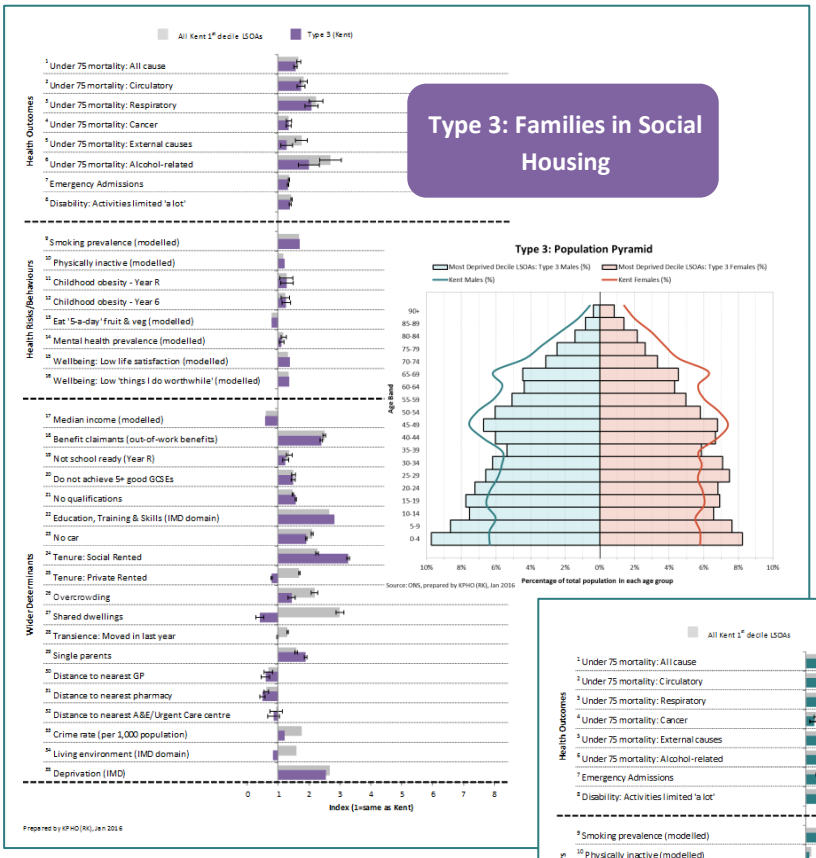
Steep inequality gradients are also evident across a large number of health and social indicators in Kent. On many measures the most deprived deciles fare disproportionately worse than their more affluent counterparts (i.e. there is a non-linear relationship with deprivation). For example, alcohol-related premature mortality is six times higher in the most deprived decile than the most affluent decile.

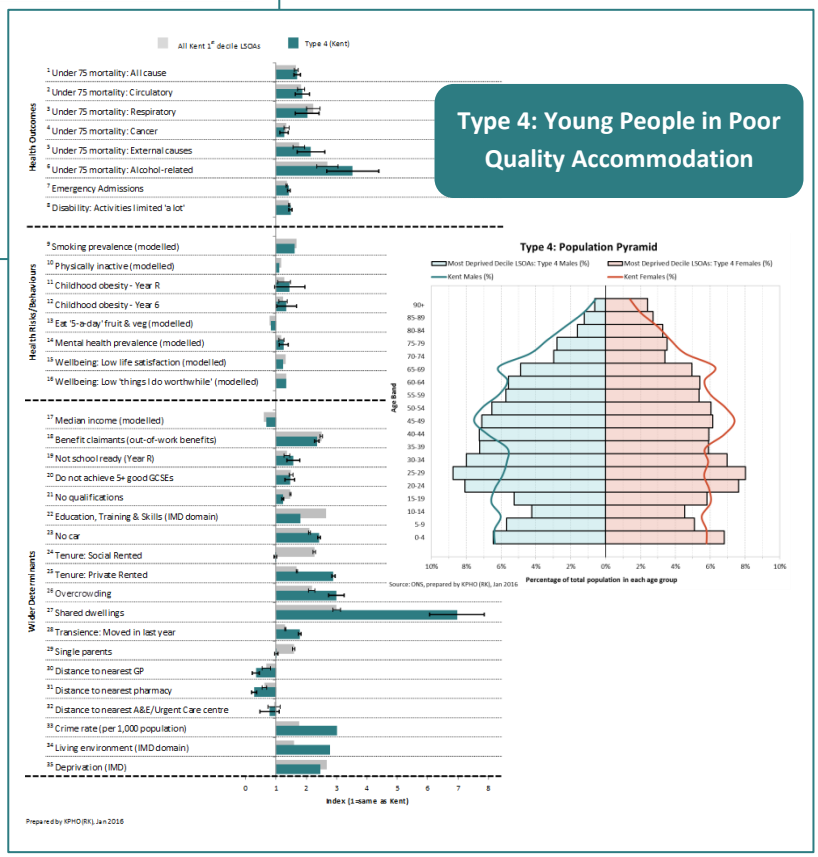
1.2.3 Types of deprivation

The LSOAs identified as falling into the most deprived decile in Kent have been subdivided using multivariate segmentation techniques. This segmentation sought to divide the most deprived LSOAs into 'types', so that within a 'type' areas are similar and between 'types' they differ. The analysis produced four distinct types.









1.3 Call to action

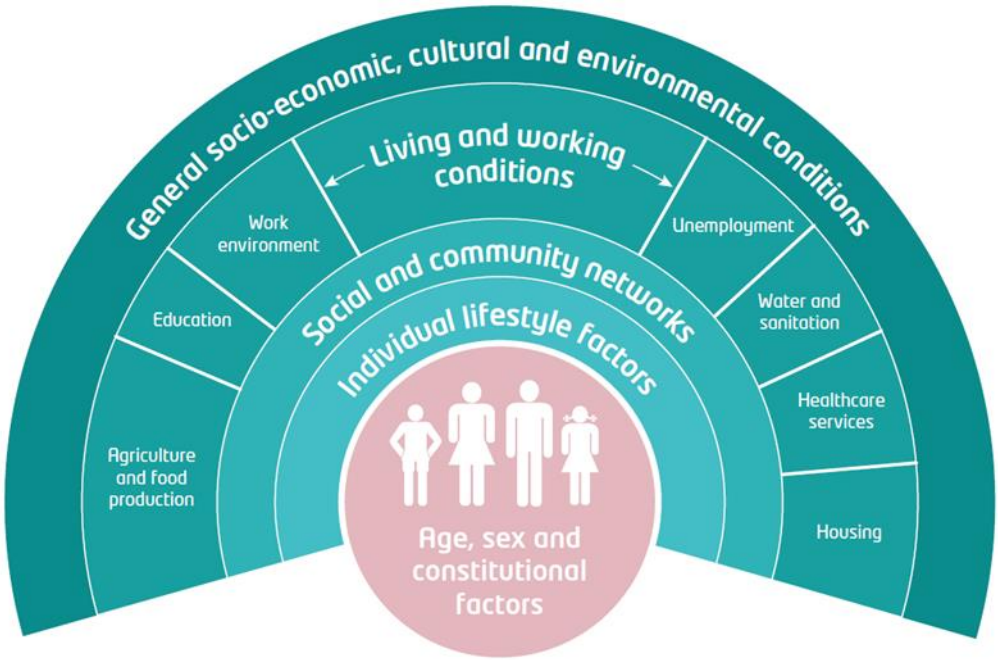
The forthcoming Mind the Gap: Health Inequalities Action Plan for Kent 2016 will include recommendations for action on health inequalities.

2. Introduction & objectives

Health inequalities are the differences in health outcomes within and between communities. We measure health inequalities overall through health statistics such as life expectancy or all-age, all-cause mortality rates or more specifically for specific disease mortality rates such as cancers, cardiovascular or respiratory disease rates.

It is now widely recognised that our health as individuals is shaped by the conditions in which we are born, grow, live, work and age[1].

Thus policy makers for health have to consider the wider set of economic, political, and social forces and systems which influence our daily lives. These wider determinants of health drive the health inequalities which exist in society; that is, the unfair and avoidable differences in health status between individuals depending on their life circumstances.



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

Whilst Kent as a whole scores above the England average on a range of health indicators, this hides the great diversity and disparities which exist within, and between, Kent's communities.

[1] UCL Institute of Health Equity. Fair Society, Healthy Lives: The Marmot Review - Strategic Review of Health Inequalities in England post-2010. 2010.

In 2012 the 'Mind the Gap' action plan was formulated by Kent County Council to reduce the gap in health status between the least deprived and most deprived communities in Kent[2]. The 2015 Public Health Annual Report[3] is dedicated to health inequalities and reinforces the need to remain focussed on reducing the 'gap' in health outcomes across the county.

As part of the work surrounding the production of the 2015 Public Health Annual Report, the Kent Public Health Observatory (KPHO) were asked to provide intelligence and analytic support to bring greater understanding of the true nature of the health inequalities we see in Kent. This work has also been used to inform the forthcoming Mind The Gap: Health Inequalities Action Plan for Kent 2016[4].

The specific objectives of our analysis were as follows:

- To explore trends in inequalities in health outcomes in Kent
- To explore inequalities in both health outcomes and the wider determinants of health
- To provide further understanding of the most deprived areas in Kent, using segmentation techniques to help describe our most deprived areas.

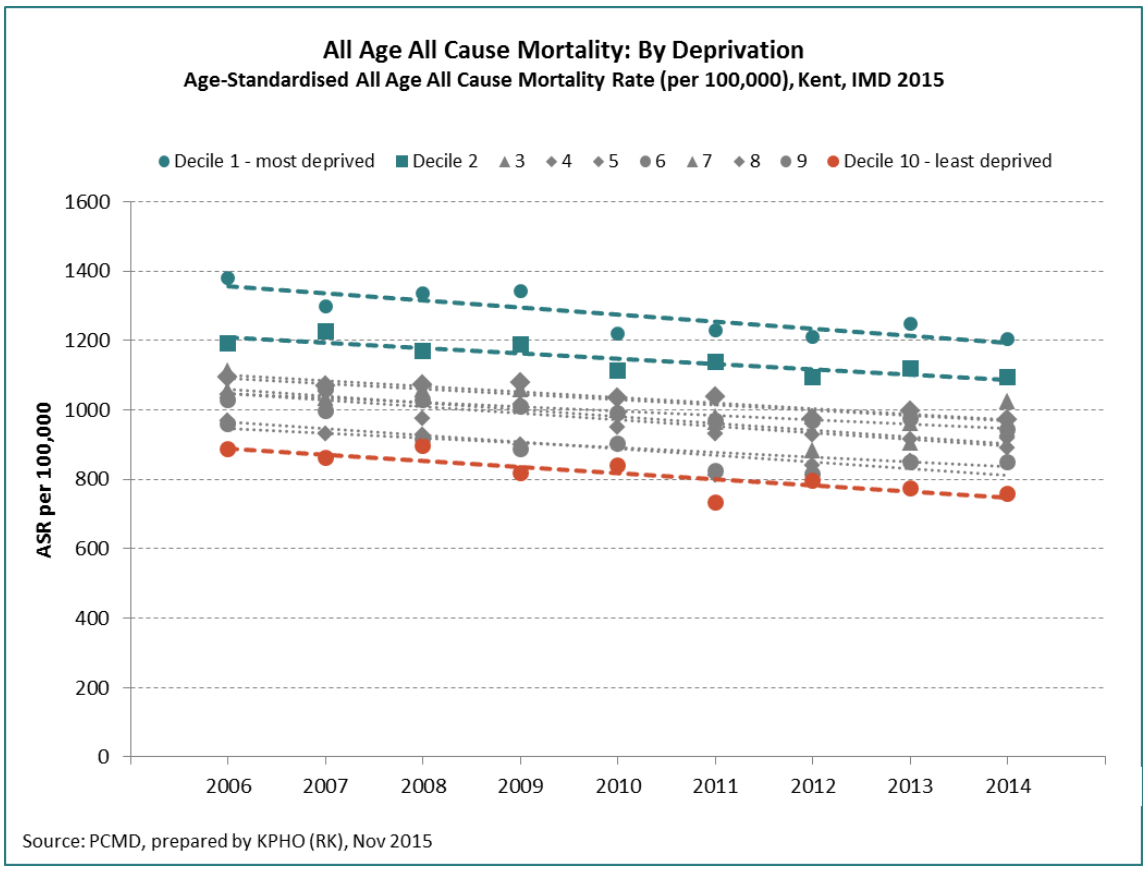
This analytical report describes the analysis we conducted and details the key findings. It should be read in conjunction with the 2015 Public Health Annual Report and the Mind The Gap: Health Inequalities Action Plan for Kent 2016 which it informs.

[2] Kent County Council. Mind The Gap: Kent's Health Inequalities Action Plan 2012/15. 2012:1-62
[3] Kent County Council. Kent Annual Public Health Report 2015: Health Inequalities (http://www.kpho.org.uk/__data/assets/pdf_file/0005/57407/Final-Public-Health-Annual-Report-2015.pdf).
[4] Kent County Council. Mind The Gap: Health Inequalities Action Plan for Kent 2016. Due for publication following County Council on 15th September 2016.

3. Inequalities in mortality & life expectancy

3.1 Trends in health inequalities

The chart below shows how the differences in all age, all cause mortality rates in Kent by deprivation decile have changed over time[5].



This analysis demonstrates that, whilst mortality rates in Kent have been falling over the last decade, the 'gap' in mortality rates between the most deprived and least deprived persists. The gap is particularly large for the most deprived deciles. This demonstrates how improving the health of an entire population does not necessarily address the health inequalities that exist between different parts of society. This persistent gap in health outcomes is not a phenomenon that is unique to Kent; the ONS recently reported that there has been a persistent fixed gap in the life expectancy across England as a whole[6]. This is consistent with the latest findings from the Global Burden of Disease Study[7]: that there are marked health

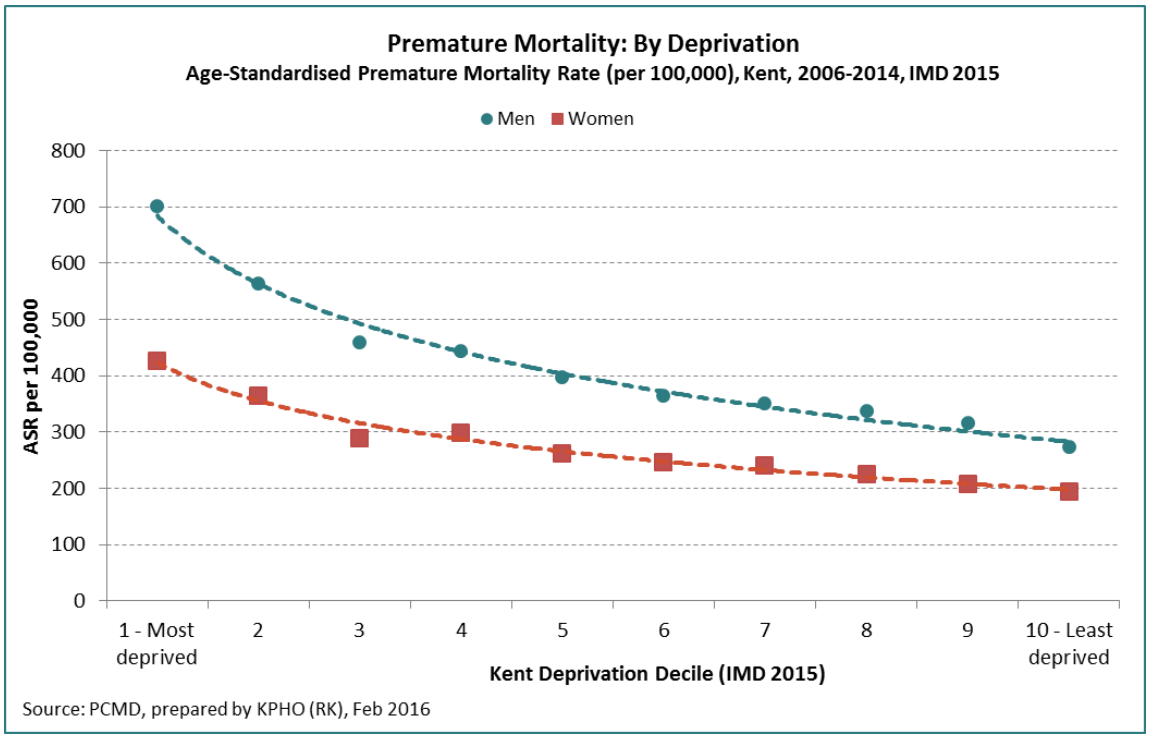
[5] In this analysis deprivation is measured via the Indices of Multiple Deprivation (IMD 2015) at LSOA-level, with the 902 LSOAs in Kent divided into population weighted deciles based on the overall IMD scores.
[6] Office for National Statistics. Statistical Bulletin Health Expectancies at birth by Middle Layer Super Output Areas , England , Inequality in Health and Life Expectancies within Upper Tier Local Authorities : 2009 to 2013. 2015:1-22.
[7] Newton JN, Briggs ADM, Murray CJL, et al. Changes in health in England, with analysis by English regions and areas of deprivation , 1990 – 2013 : a systematic analysis for the Global Burden of Disease Study 2013. Lancet.

inequalities between the most and least deprived in England despite increases in overall life expectancy.

3.2 Inequality slopes

Health inequalities lead to inequalities in life expectancy. The analysis below looks both at life expectancy and premature mortality (deaths occurring under the age of 75 years) as it is these early deaths which lead to shorter life expectancy.

3.2.1 Premature mortality



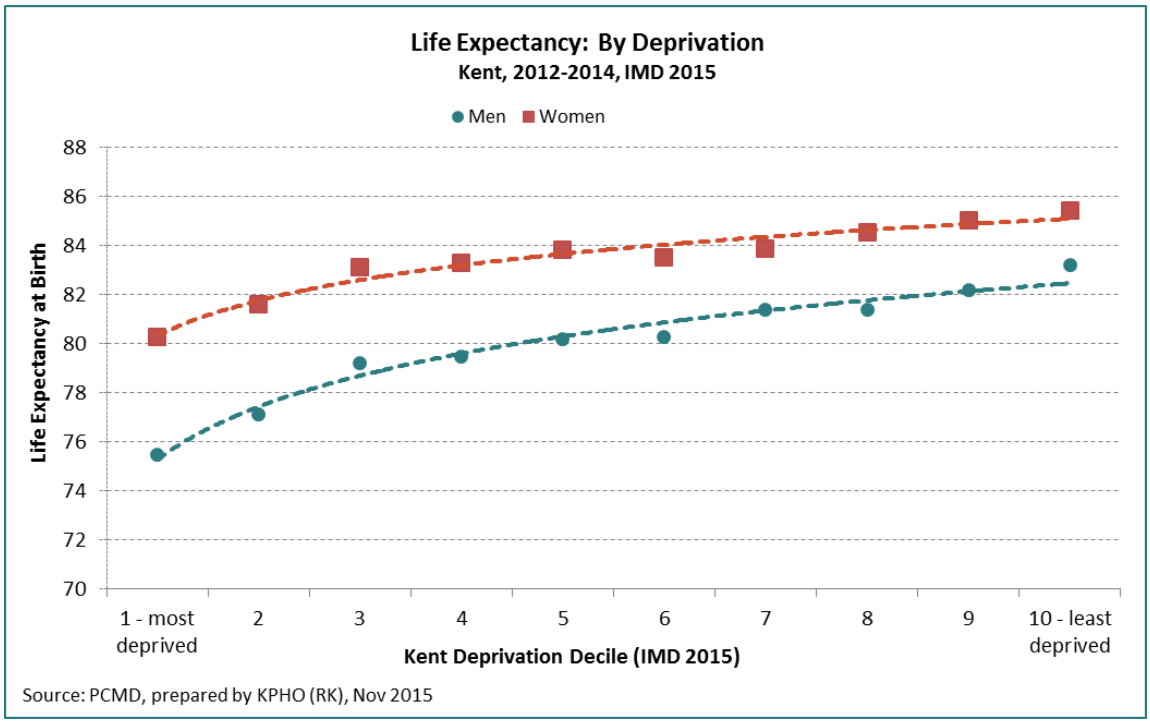
It is notable that the most deprived populations have disproportionately worse premature mortality, demonstrated by the non-linear curves of best-fit[8]. The most deprived decile in both men and women fare particularly poorly. In fact, in the most deprived decile, the premature mortality rate is more than double the rate in the most affluent decile.

In this analysis logarithmic trend lines have been used. It is clear from visual inspection alone that the relationship between deprivation and premature mortality is non-linear. In particular, the deviations from a linear trend line are clearly systematic in nature for the most deprived deciles. In the case of premature mortality the logarithmic trend lines for men and women have R^2 values of 99% and 98% respectively (compared with 86% and 87% for a linear trend line).

[8] Based on logarithmic trend lines.

3.2.2 Life expectancy

The chart below shows a similar analysis for life expectancy at birth.

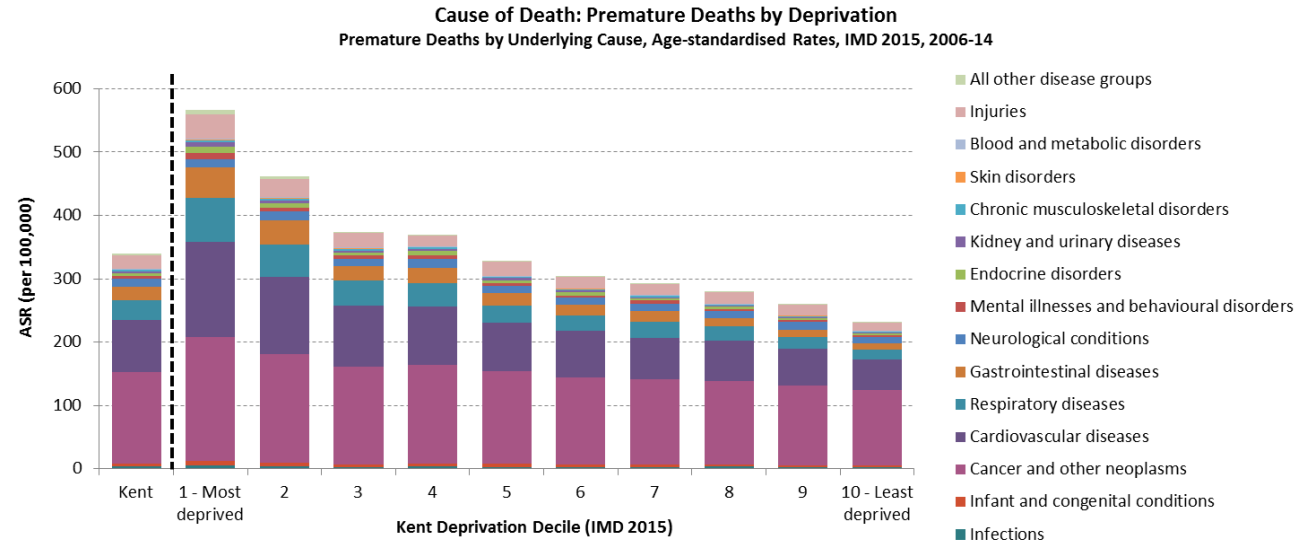


Again, the most deprived populations have disproportionately worse life expectancy, demonstrated by non-linear curves of best-fit. The most deprived decile in both men and women fare particularly poorly.

As with premature mortality, it is clear from visual inspection alone that the relationship between deprivation and life expectancy is non-linear. In particular, the deviations from a linear trend line are clearly systematic in nature for the most deprived deciles. In the case of premature mortality the logarithmic trend lines for men and women have R^2 values of 95% and 97% respectively (compared with 87% and 92% for a linear trend line).

3.3 Causes of death

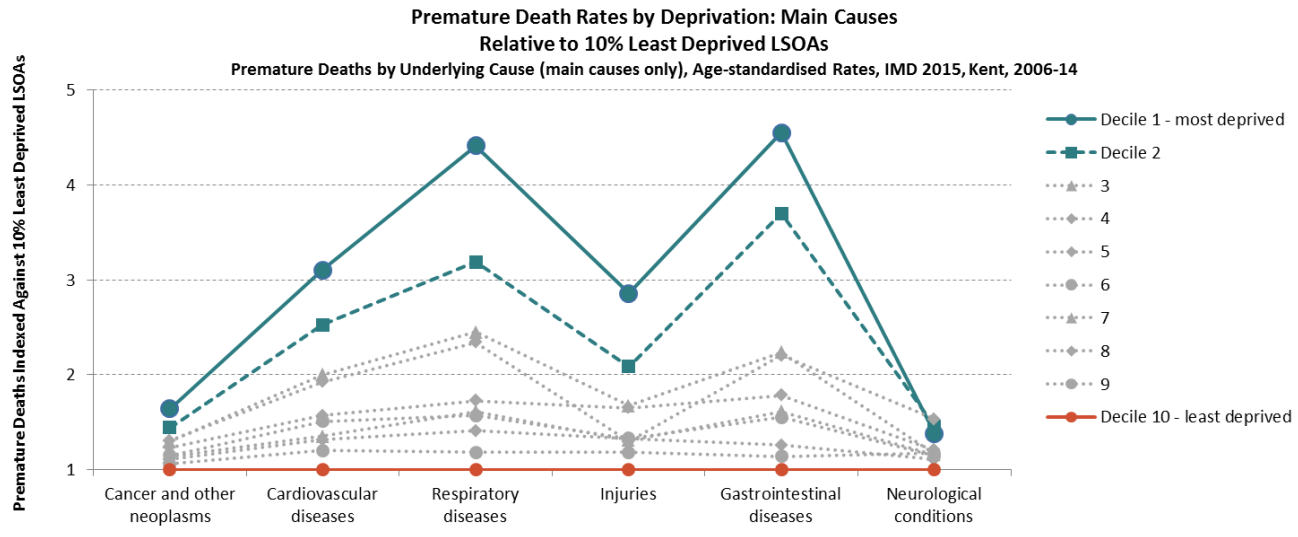
The chart below provides further analysis of premature deaths by deprivation in the context of cause of death.



Source: PCMD, prepared by KPHO (RK), April 2016

This analysis not only demonstrates the higher rate of premature deaths in the most deprived deciles but also differences in the causes of premature mortality.

Cancer is the largest cause of premature mortality overall. But in the more deprived deciles, an increasing proportion of the deaths are caused by cardiovascular, respiratory and GI disease. This is demonstrated more clearly in the chart below, which indexes cause-specific premature mortality rates against the least deprived decile.



Source: PCMD, prepared by KPHO (RK), May 2016

This analysis very clearly demonstrates the inequalities in the causes of premature mortality. In particular, it highlights striking differences in cardiovascular disease, respiratory disease, GI disease and external injuries. This is an important finding, since these inequalities are amenable to being reduced through earlier detection and preventative measures, such as lifestyle modification and management of long term health risks.

4. Inequalities in the wider determinants of health

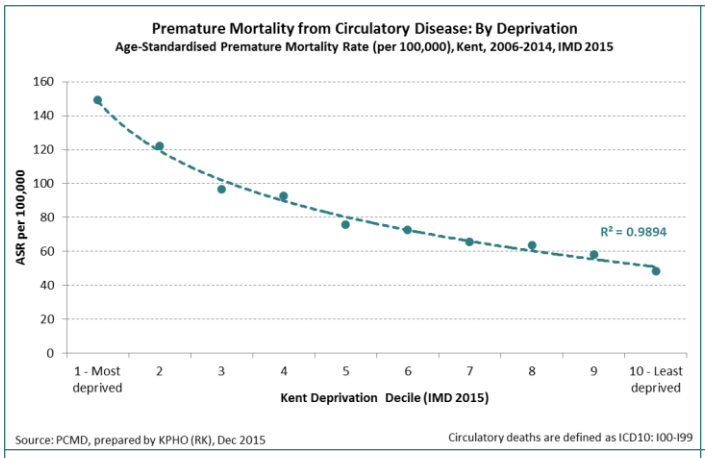
Given the inequalities in mortality rates and life expectancy, we would expect to see inequalities evident in the wider determinants of health. In this section we explore the relationship between deprivation and a range of measures of health outcomes, health risks and behaviours and the wider determinants of health. This analysis is again based on LSOA-level deprivation, with LSOAs grouped into deciles, and so requires LSOA-level data for each of the wider determinants. Analysis has been conducted for known social determinants of health, for which data exists or can be modelled at LSOA level[9].

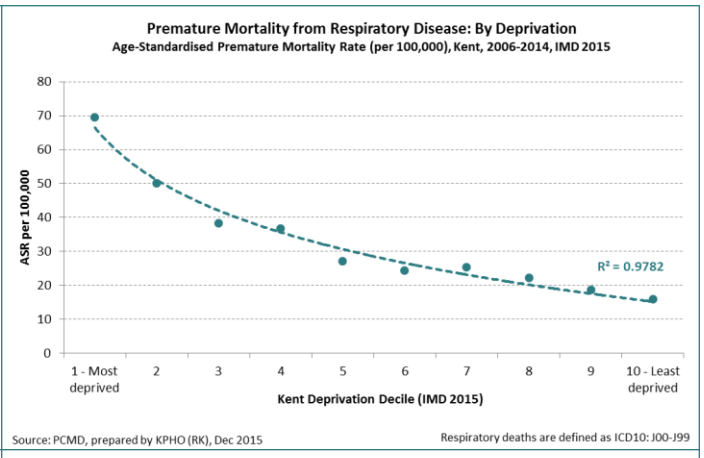
The charts overleaf show inequality slopes for a range of health outcome measures, measures of health risks and behaviours, and wider determinants of health.

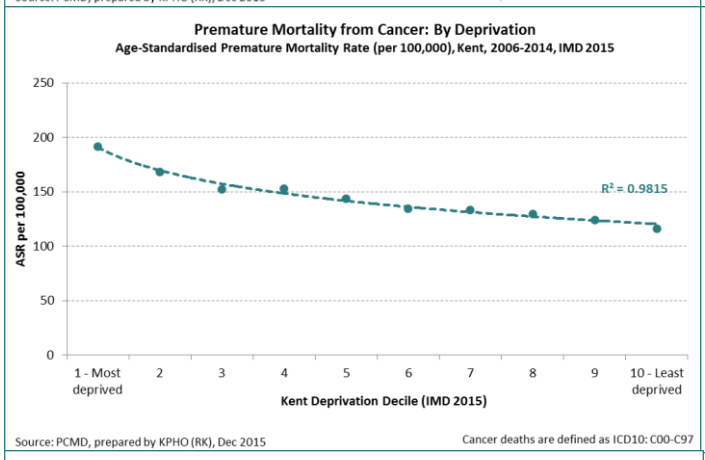
It is striking how steep inequality gradients are evident across a large number of health and social indicators in Kent. For example, in the most deprived decile, 66% of children do not achieve 5 good GCSEs, compared to 23% in the most affluent decile. Taking all the charts together, it is clear to see how poor social conditions and unhealthy behaviours reinforce one another and accumulate in individuals throughout their lives. Where the relationship is linear, those in the most deprived deciles fare worse than those in the least deprived deciles, to a degree that is proportionate to the slope of inequality. On many measures the gradient is not linear but rather curves sharply for the most deprived deciles. In these instances the most deprived deciles fare disproportionately worse than their more affluent counterparts. For example, alcohol-related premature mortality is six times higher in the most deprived decile than the most affluent decile.

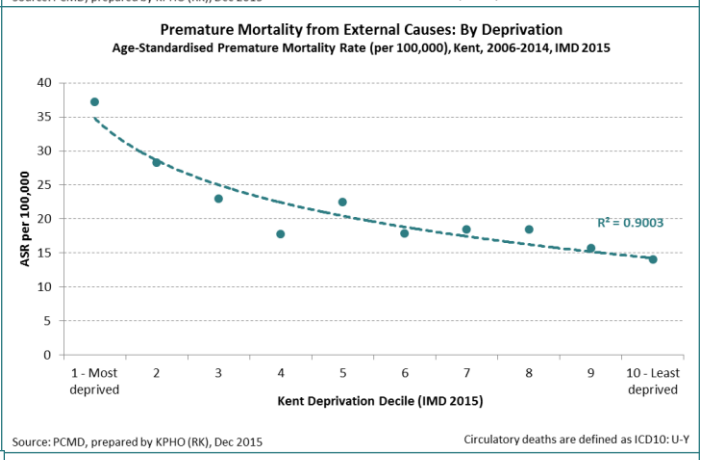
[9] Appendix A provides details of the data sources and modelling approaches.

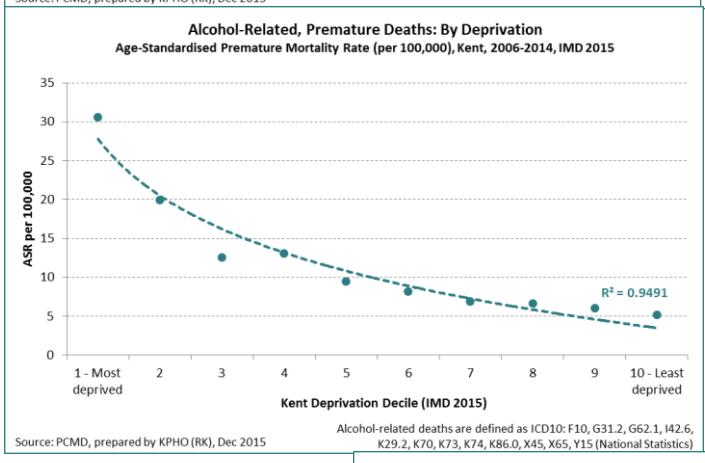
4.1 Inequality slopes: Health outcomes

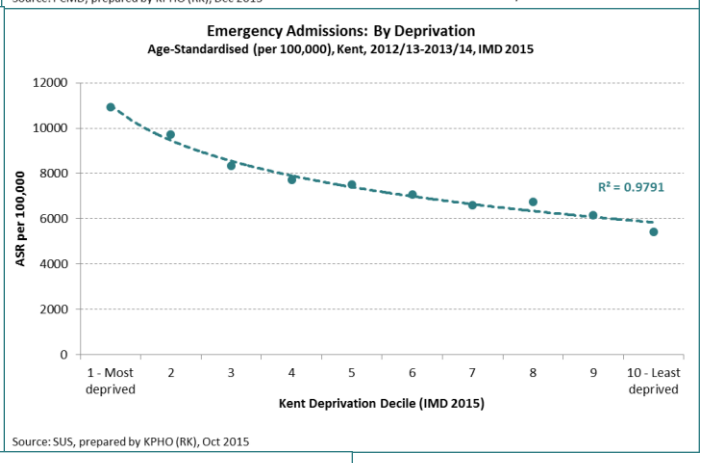


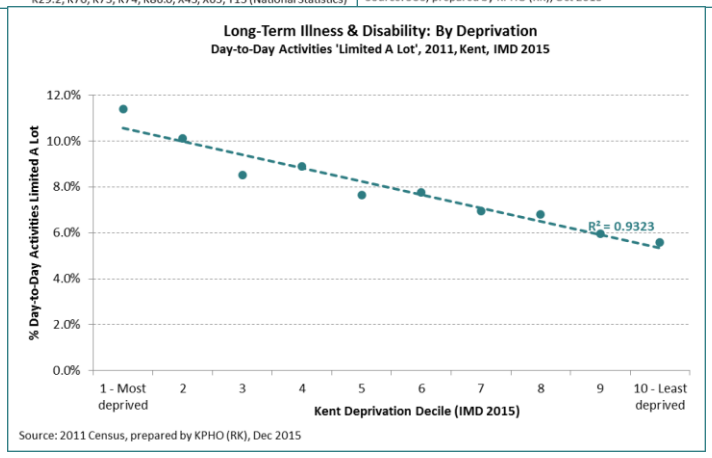




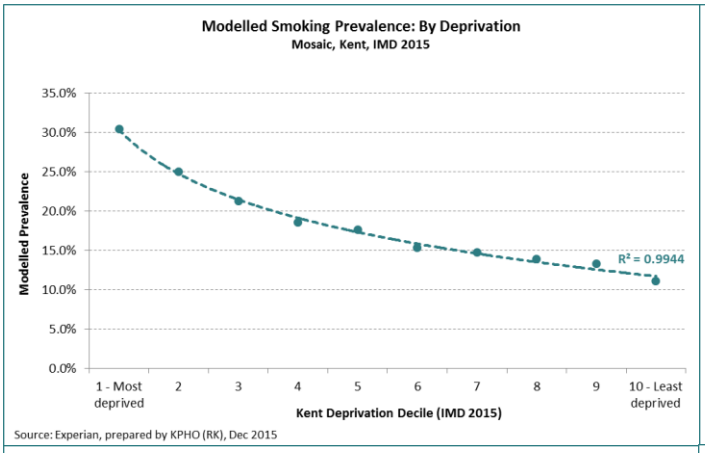


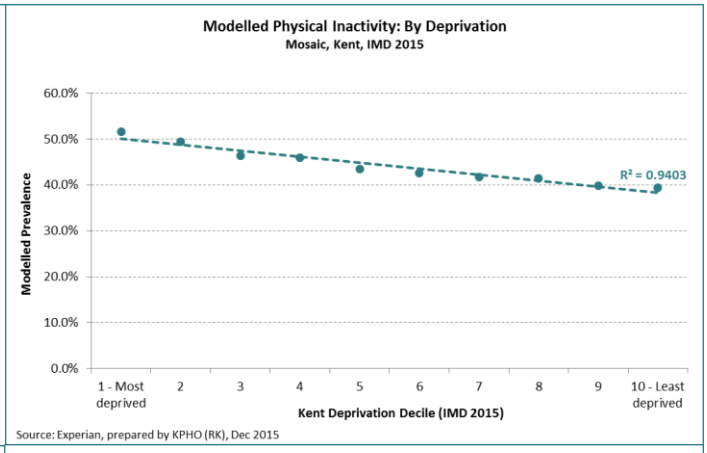


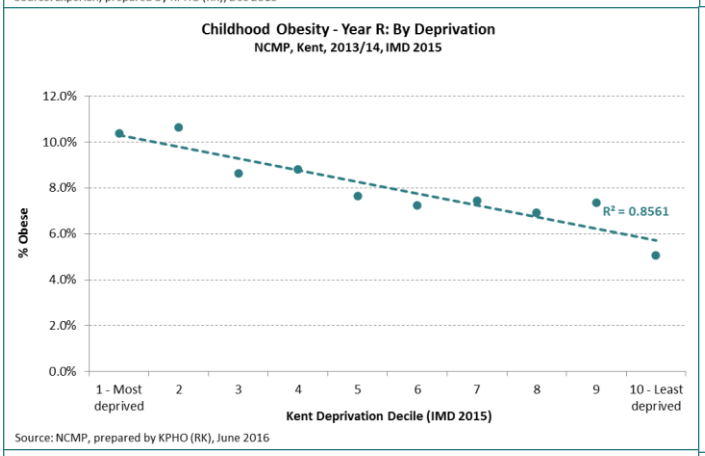


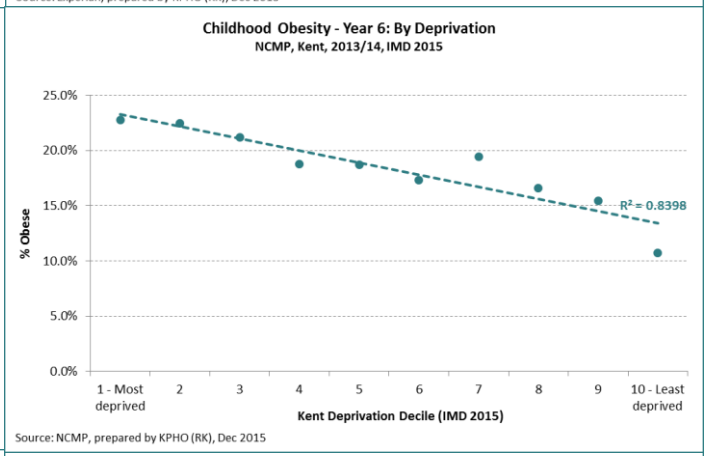


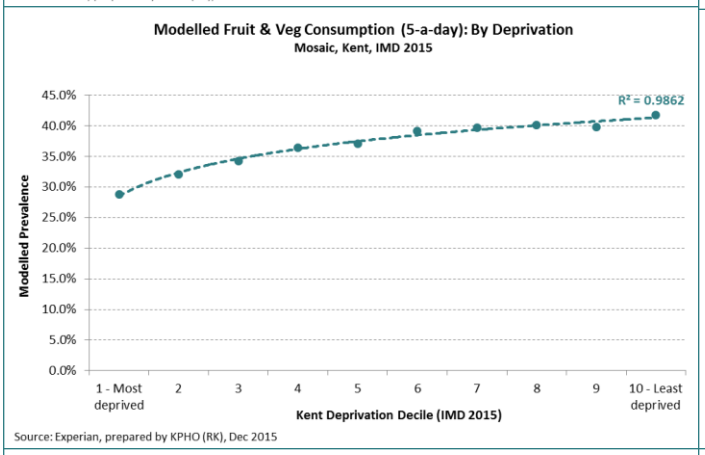
4.2 Inequality slopes: Health risks & behaviours

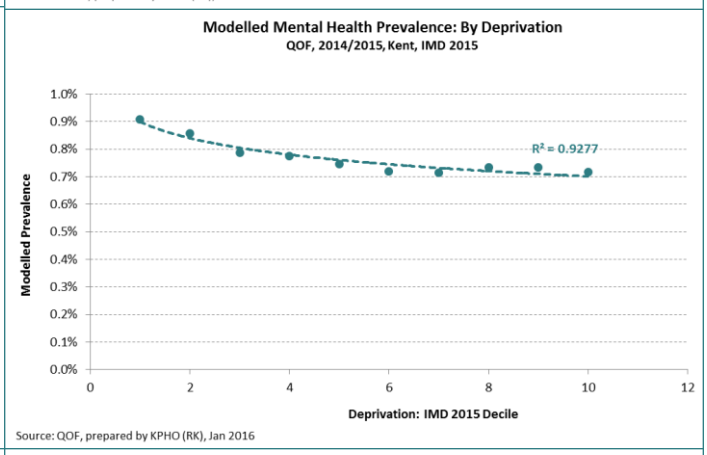


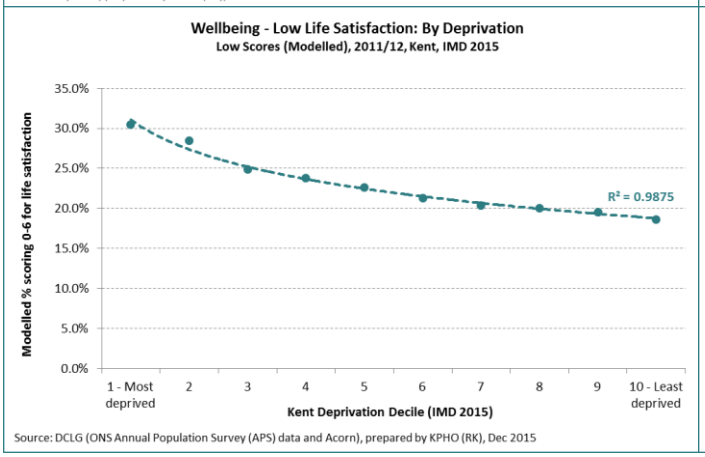


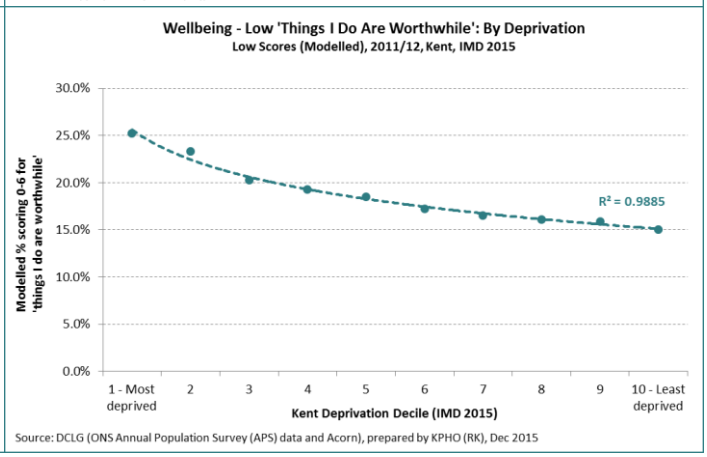




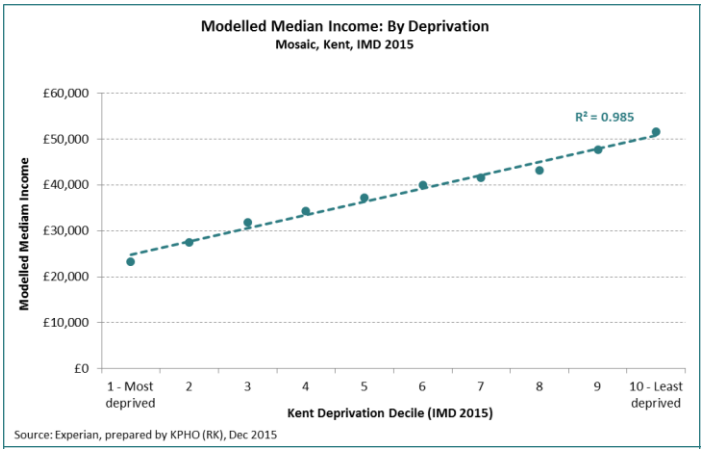


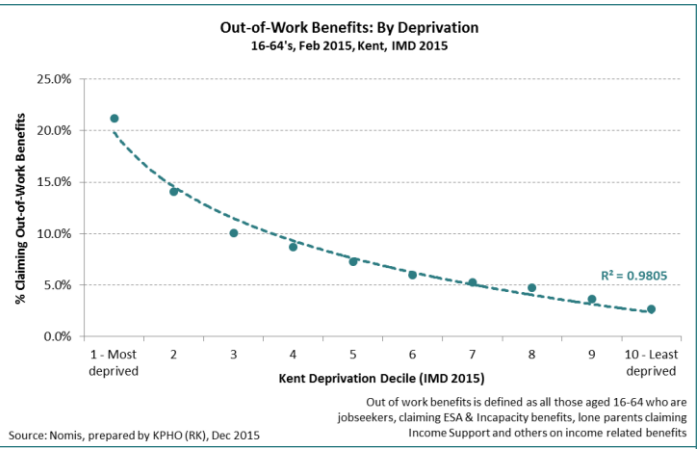


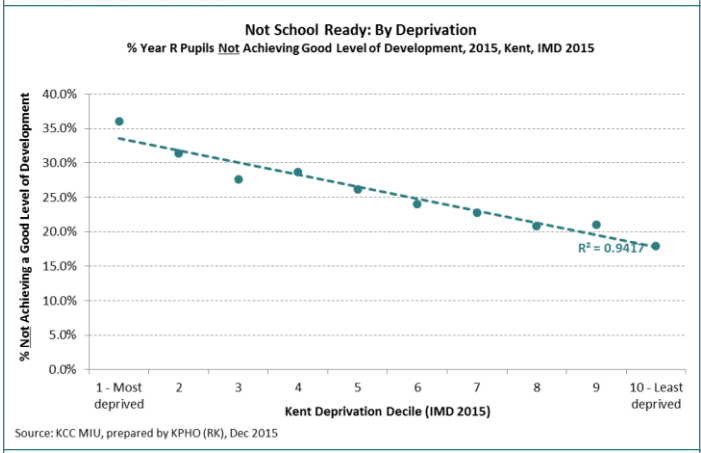


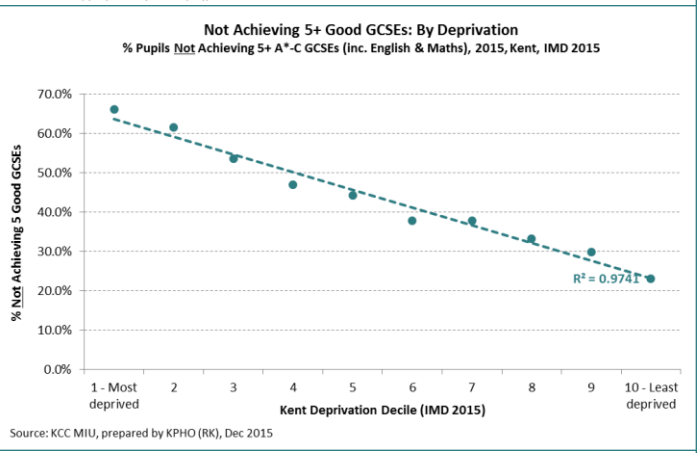


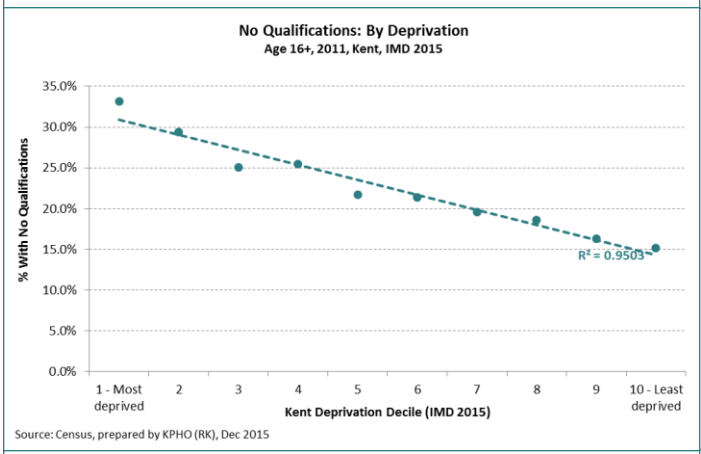
4.3 Inequality slopes: Wider determinants of health

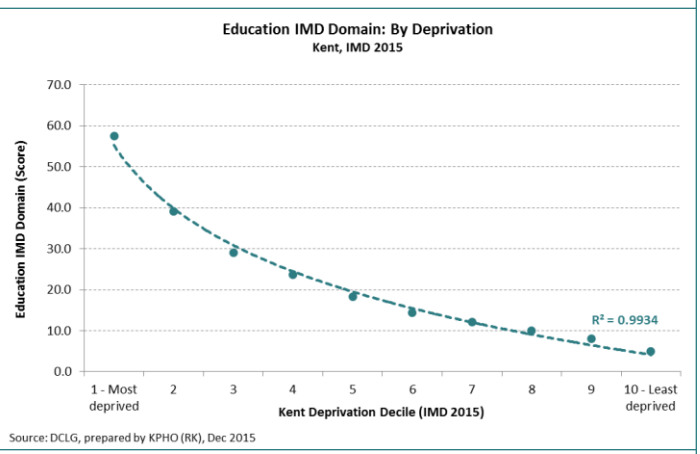


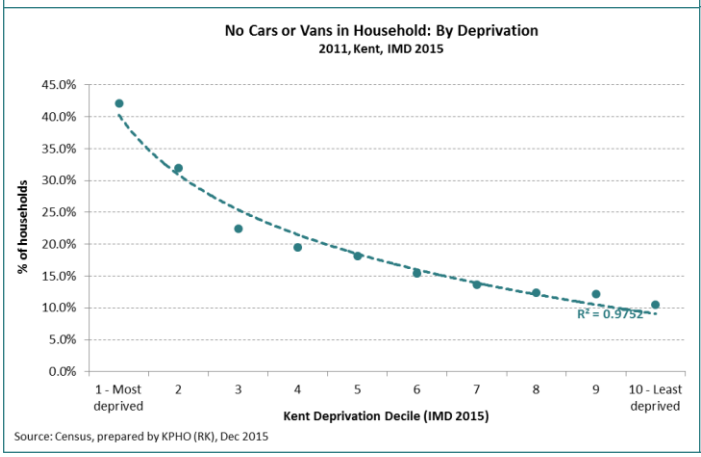


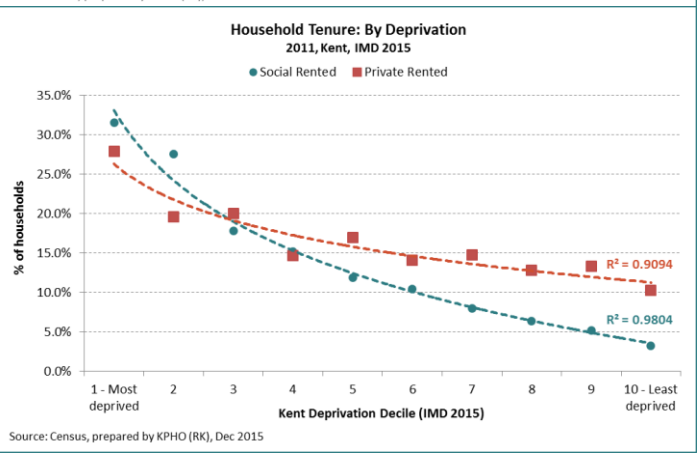


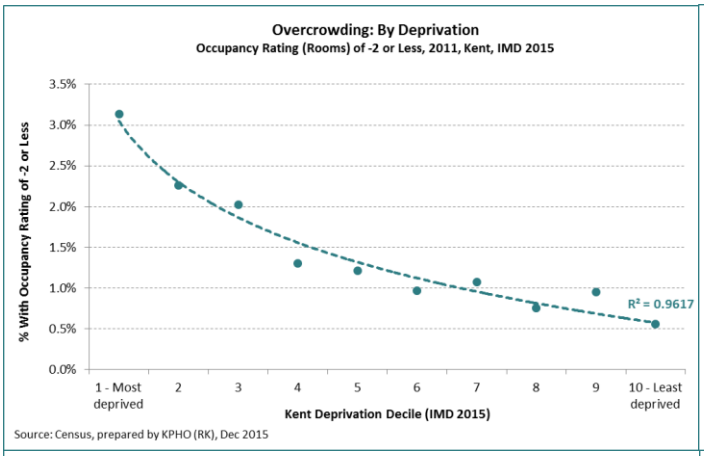




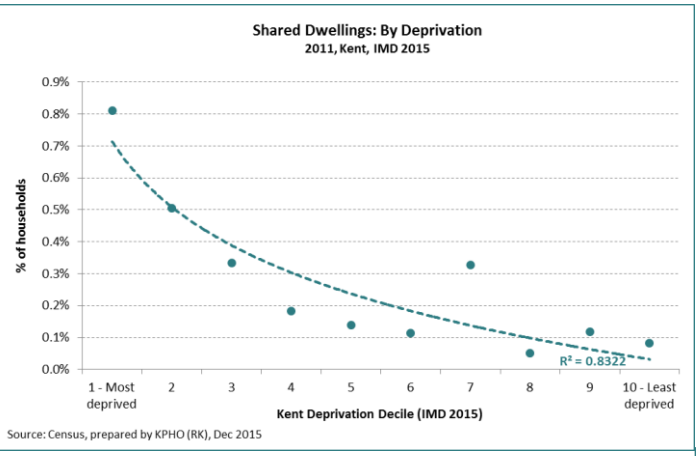




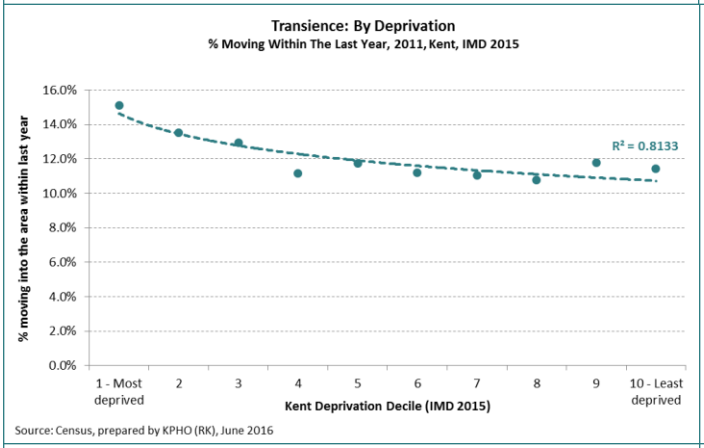




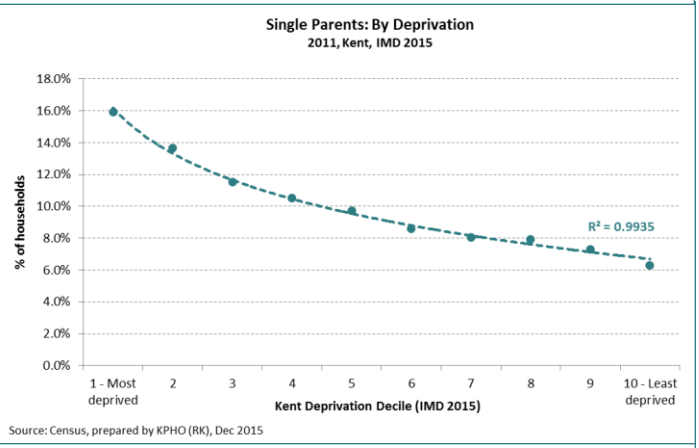
Source: Census, prepared by KPHO (RK), Dec 2015



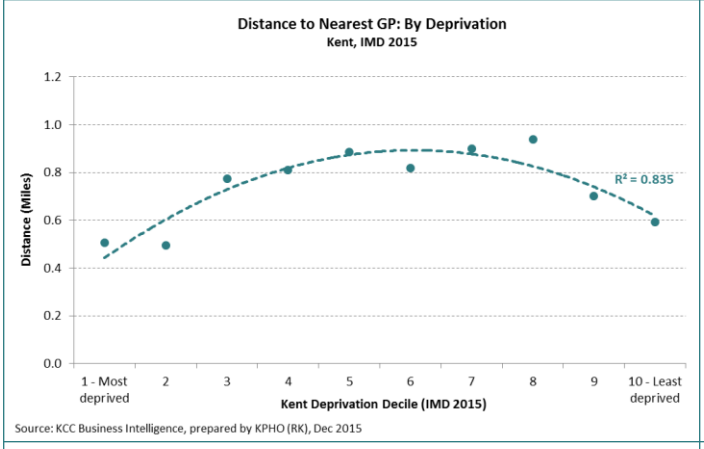
Source: Census, prepared by KPHO (RK), Dec 2015



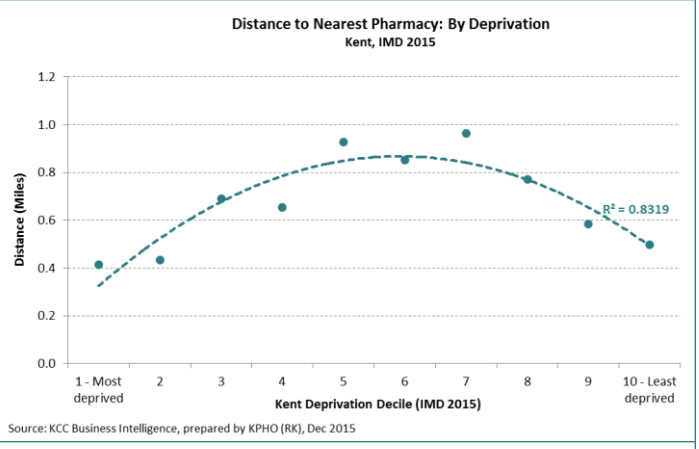
Source: Census, prepared by KPHO (RK), June 2016



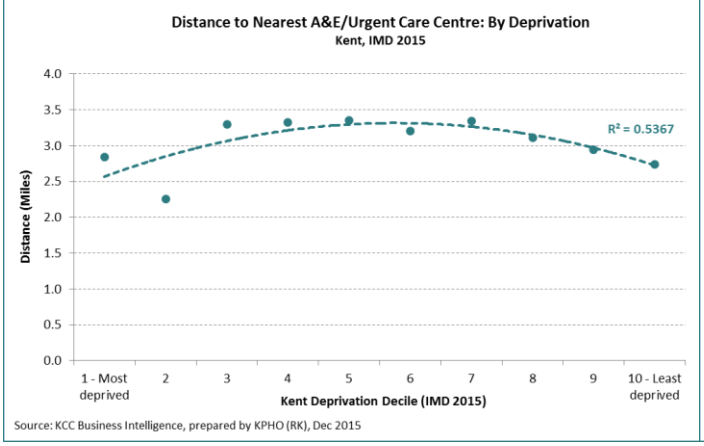
Source: Census, prepared by KPHO (RK), Dec 2015



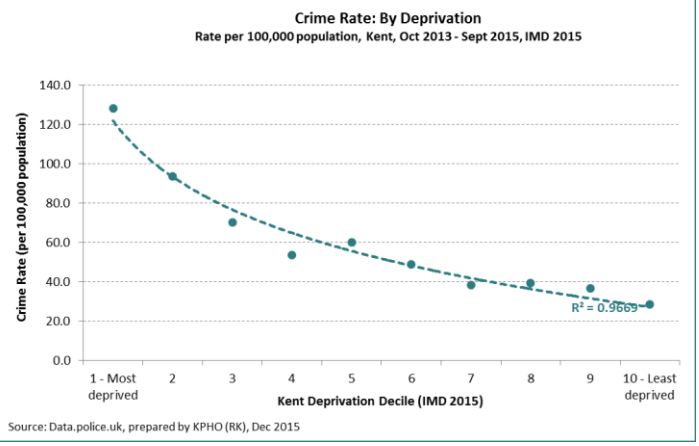
Source: KCC Business Intelligence, prepared by KPHO (RK), Dec 2015



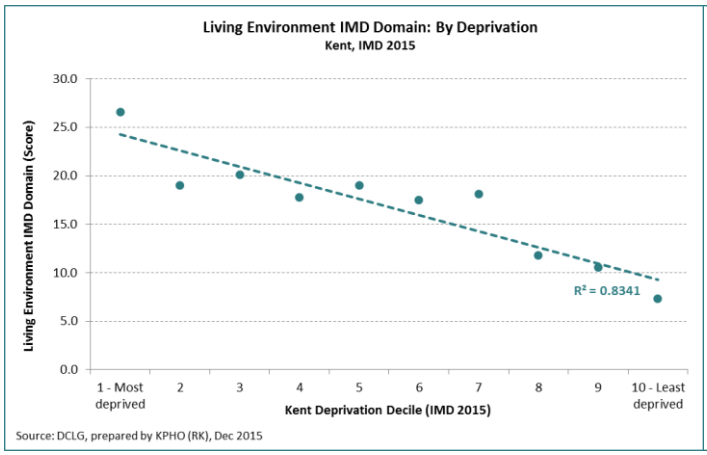
Source: KCC Business Intelligence, prepared by KPHO (RK), Dec 2015

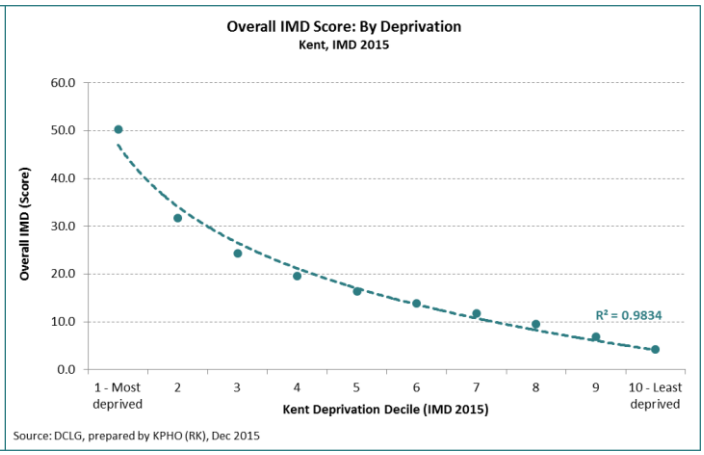


Source: KCC Business Intelligence, prepared by KPHO (RK), Dec 2015



Source: Data.police.uk, prepared by KPHO (RK), Dec 2015





5. Types of deprivation

The above analysis clearly identifies the populations of the areas falling into the most deprived decile in Kent as suffering from disproportionately poor health outcomes and being disproportionately likely to display a number of characteristics associated with poor health outcomes. Before we can improve health outcomes in the most deprived areas, we need to gain deeper insights into the characteristics of the populations and the challenges they face.

The analysis in this section attempts to address concerns relating to treating the most deprived decile as a single homogenous group. Within this decile different local areas will face different challenges and so potentially require different interventions and approaches. However, it was our hypothesis that there exists some degree of commonality between certain groups of LSOAs falling into the most deprived decile.

5.1 Segmentation

The 88 LSOAs identified as falling into the most deprived decile have been subdivided using multivariate segmentation techniques. This segmentation seeks to divide the most deprived LSOAs into 'types', so that within a 'type' areas are similar and between 'types' they differ. Mosaic[10] has been used as the basis for the segmentation.

SPSS was used to run a k-means cluster analysis, which has identified relatively homogeneous groups of LSOAs based on their Mosaic profiles. The method allowed iterative identification of cluster centres. The 4-cluster solution was selected as the most

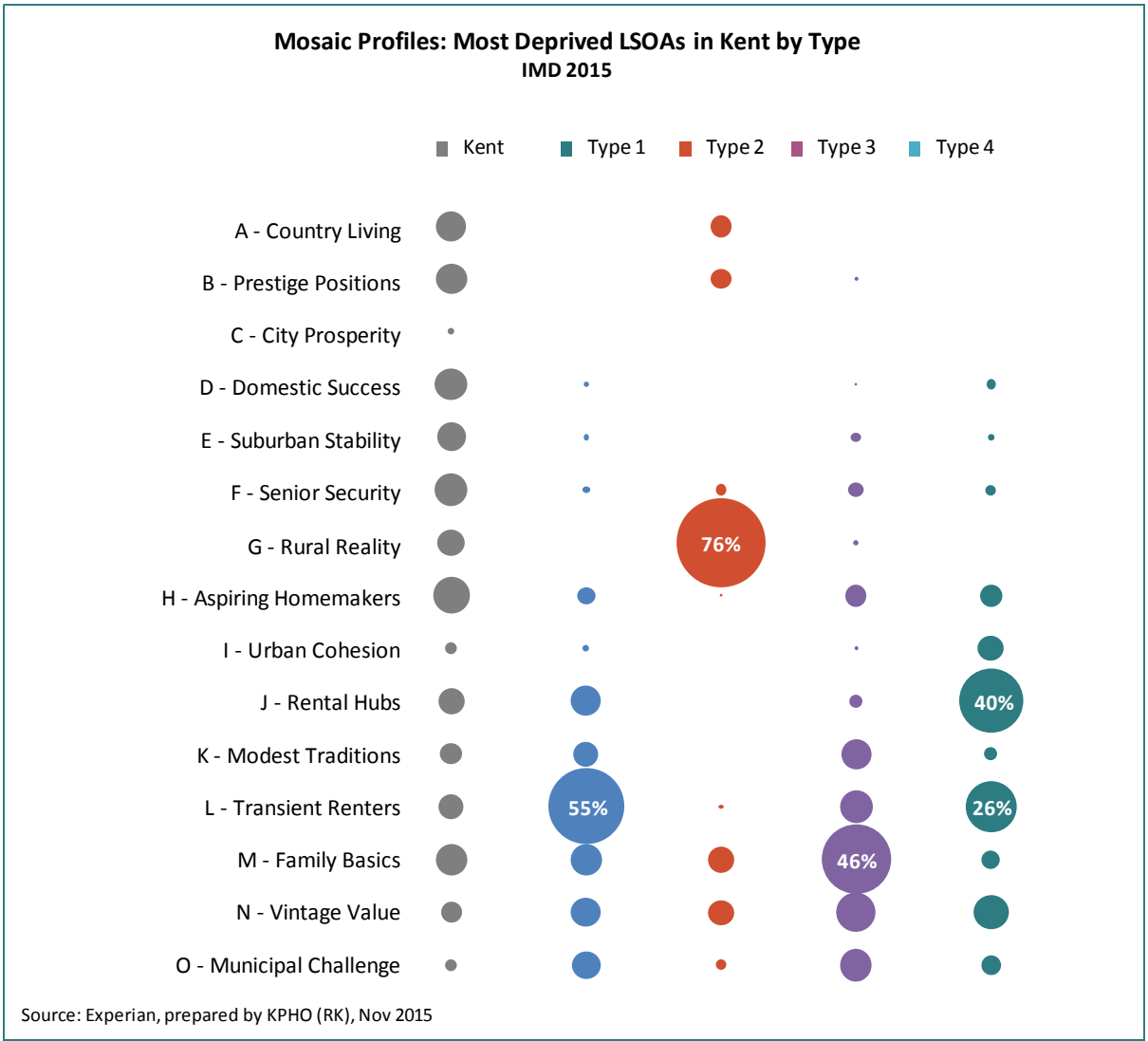
[10] MOSAIC is a population segmentation tool produced by Experian, which is increasingly being used in the public sector to better understand local populations. The classification system draws upon 450 different sources of data relating to socio-demographics, lifestyle, culture and behaviour, and then categorises households based on this.

appropriate, with the clusters labelled 'Type 1', 'Type 2', 'Type 3' and 'Type 4'. Appendix C gives a full listing of the type allocated to each of the 88 LSOAs falling within Kent's most deprived decile.

Based on the detailed analysis contained later within this section, the clusters were given names as follows:

- Type 1: Young people lacking opportunities
- Type 2: Deprived rural households
- Type 3: Families in social housing
- Type 4: Young people in poor quality accommodation.

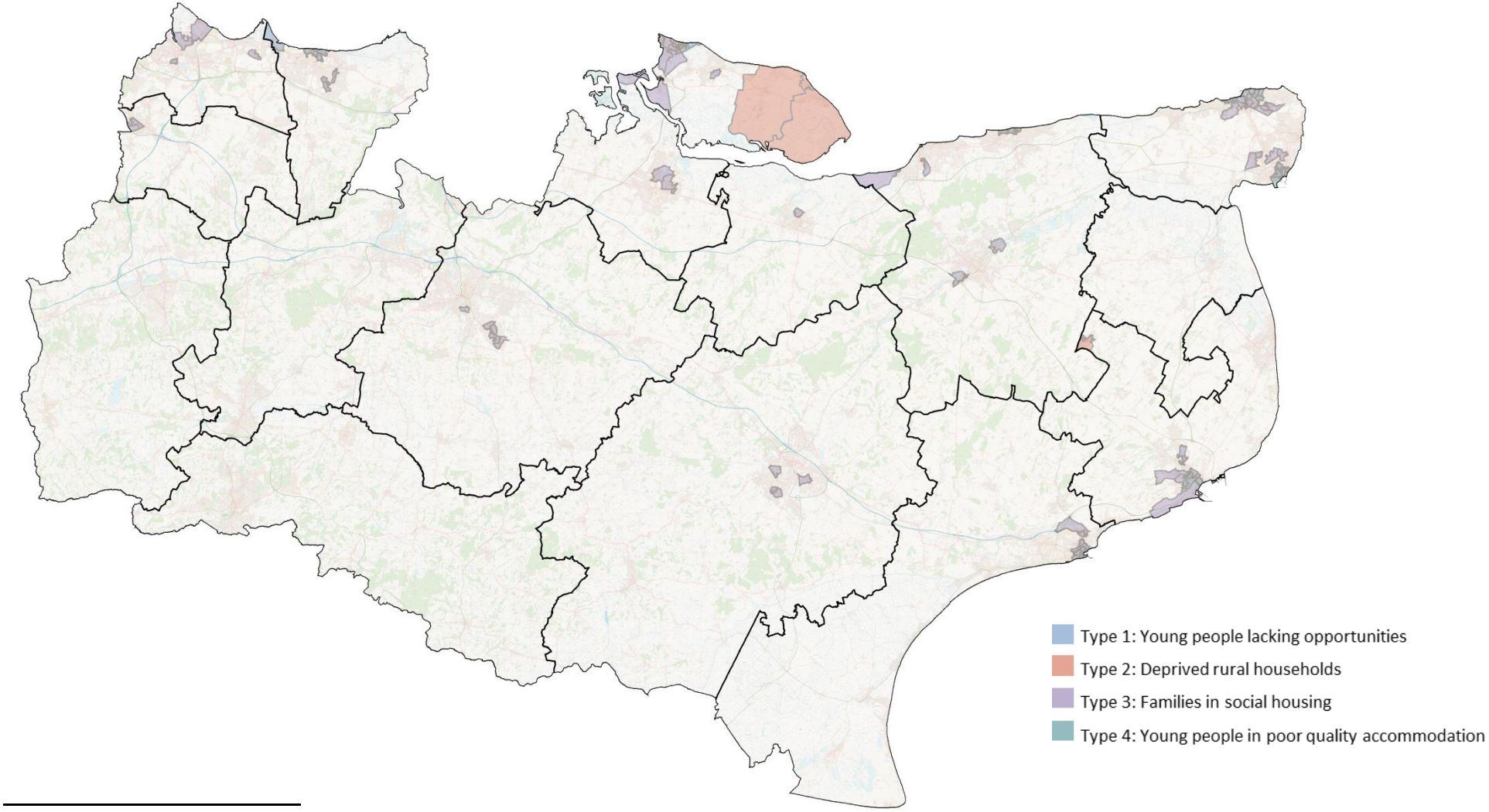
The chart below shows the Mosaic profiles of each of the four types.



There are clear differences between the four deprivation types in respect of their Mosaic profiles.

The map below shows Kent's most deprived decile LSOAs by type[11].

Most Deprived Decile LSOAs in Kent: By Deprivation Type

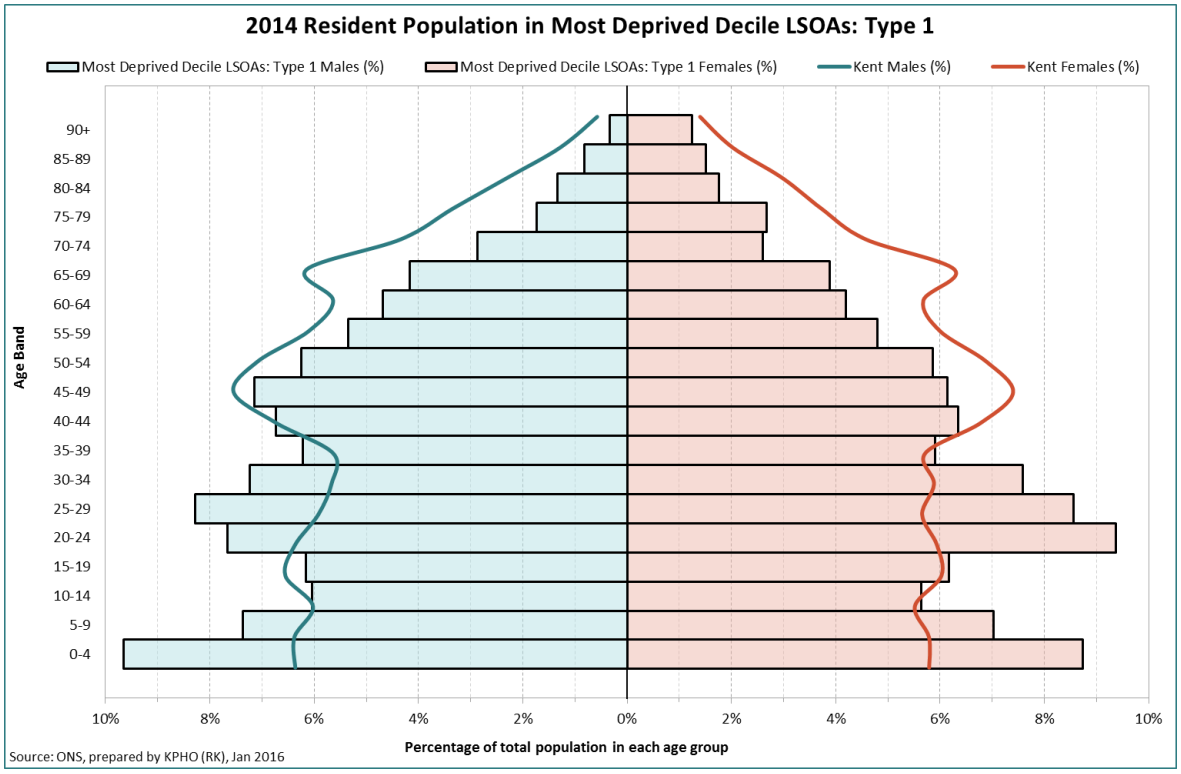


[11] More detailed local maps can be found in the CCG-level summaries contained within Appendix B.

5.2 Type 1: Young people lacking opportunities

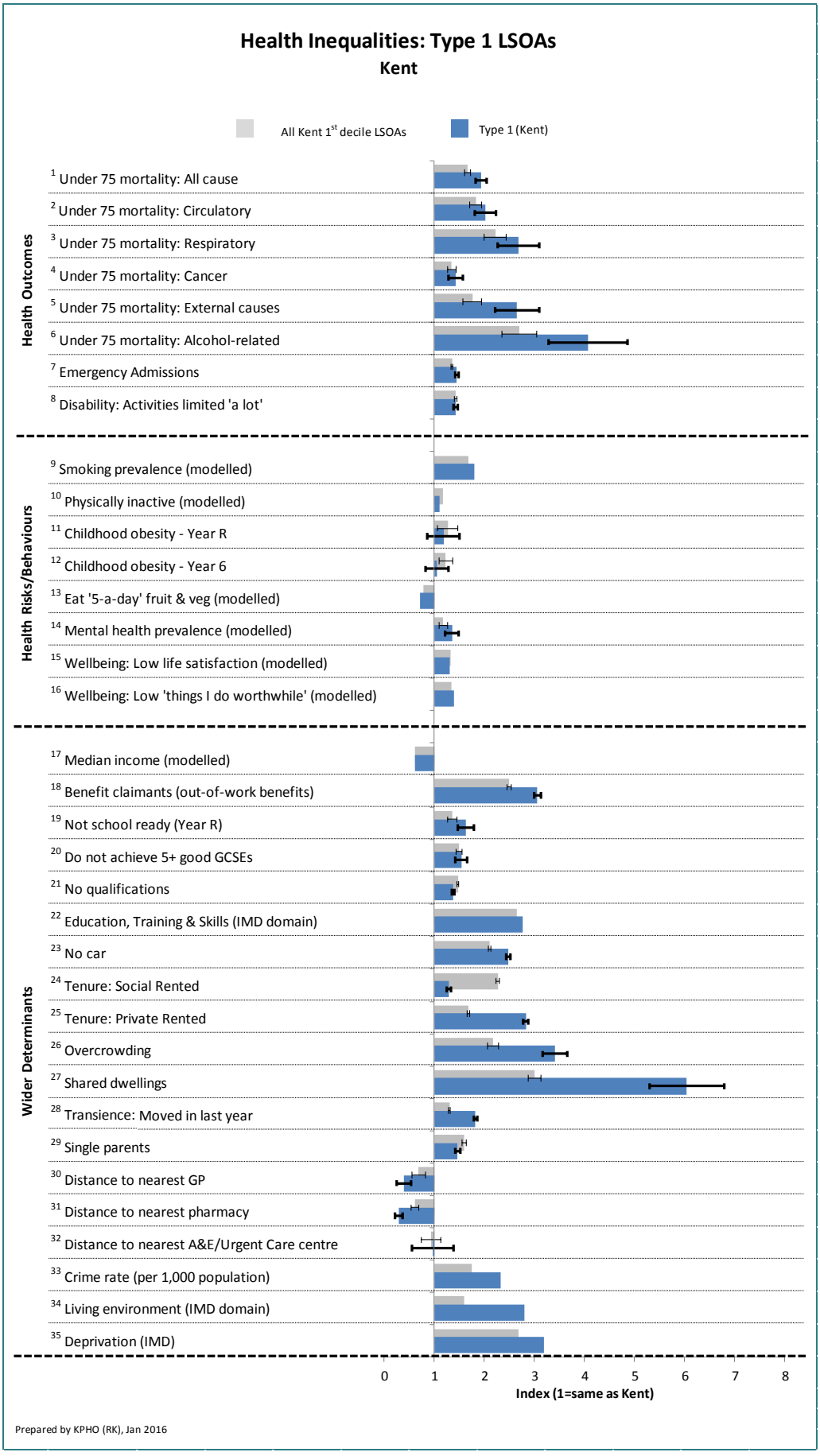
A total of 18 of the 88 most deprived decile LSOAs in Kent fall into type 1. These include LSOAs in Northfleet, Folkestone Harbour, Clarendon, Tower Hamlets, Sheerness East Margate Central, Cliftonville West and Eastcliff. For detailed local maps of the individual LSOAs falling into this cluster see the CCG-level summaries in Appendix B.

The chart below shows the age structure of the population of type 1 deprived areas in comparison with Kent as a whole.



This analysis shows that type 1 deprived areas have high numbers of young adults and of young children.

The chart overleaf provides a summary of the characteristics of type 1 deprived areas in terms of health outcomes, health risks and behaviours, and the wider determinants of health. In this analysis type 1 deprived areas have been indexed against the average for Kent for each individual characteristic. Also shown is data for the most deprived decile as a whole. For details of the data sources used for each characteristic see Appendix A.


Health Inequalities: Type 1 LSOAs
Kent
All Kent 1st decile LSOAs
Type 1 (Kent)
Health Outcomes
1 Under 75 mortality: All cause
2 Under 75 mortality: Circulatory
3 Under 75 mortality: Respiratory
4 Under 75 mortality: Cancer
5 Under 75 mortality: External causes
6 Under 75 mortality: Alcohol-related
7 Emergency Admissions
8 Disability: Activities limited 'a lot'
Health Risks/Behaviours
9 Smoking prevalence (modelled)
10 Physically inactive (modelled)
11 Childhood obesity - Year R
12 Childhood obesity - Year 6
13 Eat '5-a-day' fruit & veg (modelled)
14 Mental health prevalence (modelled)
15 Wellbeing: Low life satisfaction (modelled)
16 Wellbeing: Low 'things I do worthwhile' (modelled)
Wider Determinants
17 Median income (modelled)
18 Benefit claimants (out-of-work benefits)
19 Not school ready (Year R)
20 Do not achieve 5+ good GCSEs
21 No qualifications
22 Education, Training & Skills (IMD domain)
23 No car
24 Tenure: Social Rented
25 Tenure: Private Rented
26 Overcrowding
27 Shared dwellings
28 Transience: Moved in last year
29 Single parents
30 Distance to nearest GP
31 Distance to nearest pharmacy
32 Distance to nearest A&E/Urgent Care centre
33 Crime rate (per 1,000 population)
34 Living environment (IMD domain)
35 Deprivation (IMD)
0 1 2 3 4 5 6 7 8
Index (1=same as Kent)
Prepared by KPHO (RK), Jan 2016

Type 1 deprived areas are characterised by high numbers of young adults in private rented accommodation.

This analysis highlights the following key characteristics of type 1 deprived areas in respect of some of the wider determinants of health, and in comparison with Kent as a whole:

- Particularly high levels of shared dwellings and overcrowding
- Particularly poor living environment with particularly high crime rates
- Low incomes
- Particularly high levels of out-of-work benefit claimants
- Poor scores for education
- Particularly high levels of movement/transiency.

In terms of health risks and behaviours, type 1 deprived areas have:

- High smoking prevalence
- Low levels of wellbeing.

In terms of health outcomes, type 1 deprived areas have:

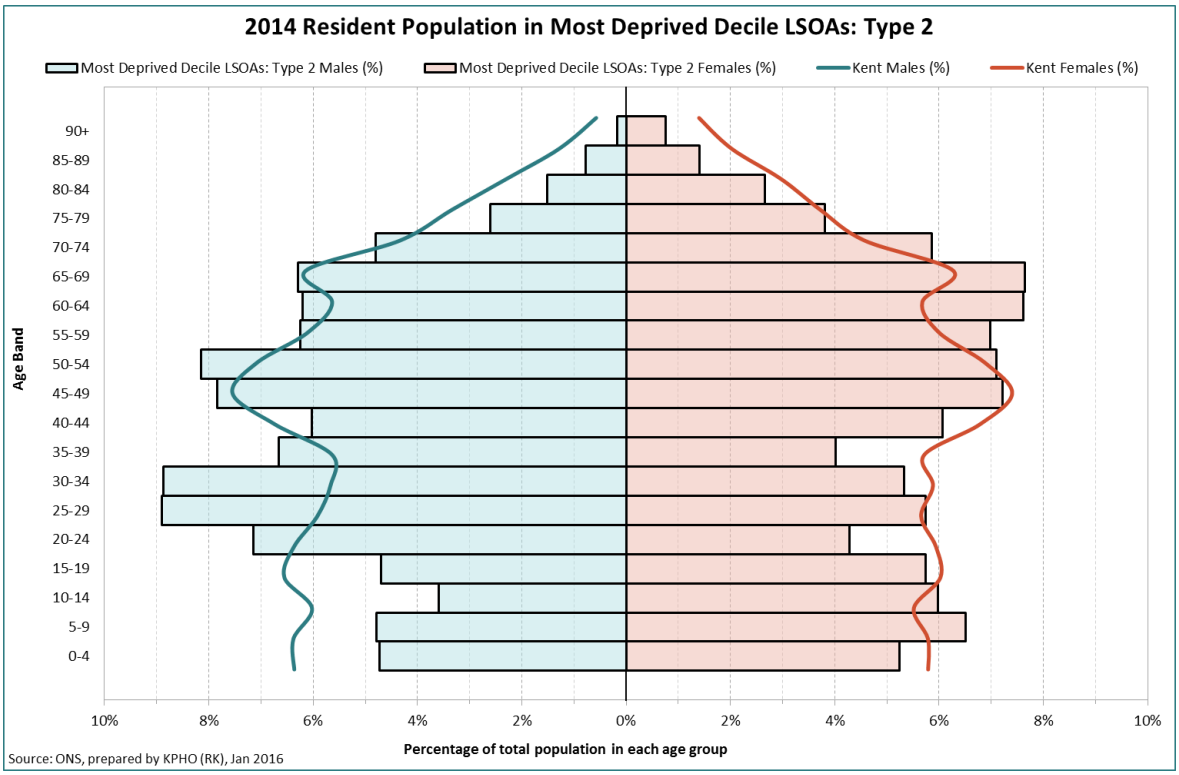
- Particularly high premature mortality rates, with alcohol-related premature mortality, premature mortality from 'external causes' particularly high
- High emergency hospital admission rates
- High rates of disability ('activities limited a lot').

Please see Appendix B for analysis of type 1 deprived areas at CCG-level, including detailed local maps for individual LSOAs falling into this cluster.

5.3 Type 2: Deprived rural households

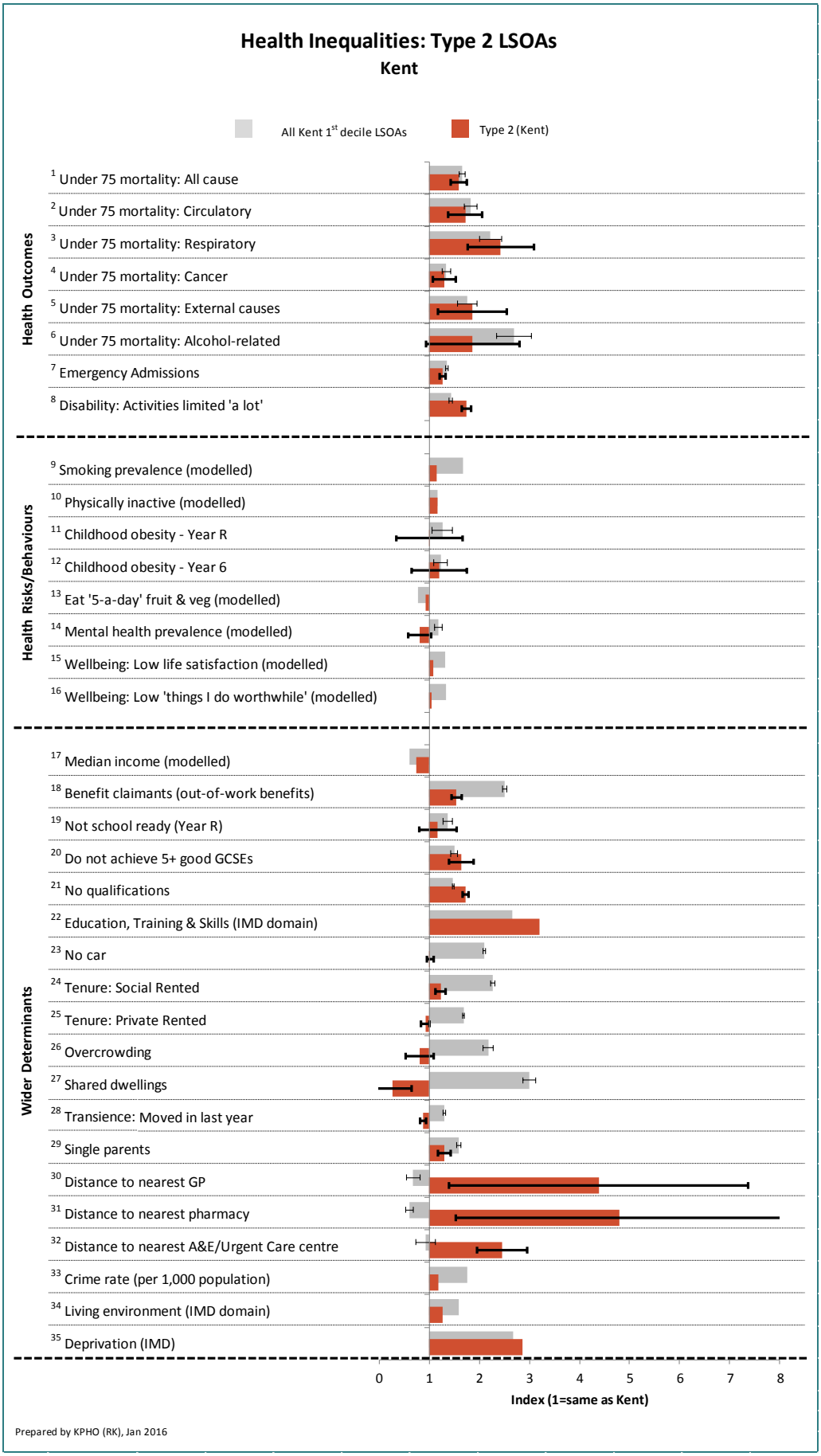
A total of 4 of the 88 most deprived decile LSOAs in Kent fall into type 2. These include LSOAs in Aylesham, Leysdown-On-Sea, Warden and Eastchurch. It must be borne in mind when interpreting the results for type 2 LSOAs that data is based on a relatively small population. For detailed local maps of the individual LSOAs falling into this cluster see the CCG-level summaries in Appendix B.

The chart below shows the age structure of the population of type 2 deprived areas in comparison with Kent as a whole.



This analysis shows that type 2 deprived areas have lower numbers of children than the Kent population as a whole (and other deprived area types).

The chart overleaf provides a summary of the characteristics of type 2 deprived areas in terms of health outcomes, health risks and behaviours, and the wider determinants of health. In this analysis type 2 deprived areas have been indexed against the average for Kent for each individual characteristic. Also shown is data for the most deprived decile as a whole.


Health Inequalities: Type 2 LSOAs
Kent
All Kent 1st decile LSOAs
Type 2 (Kent)
Health Outcomes
1 Under 75 mortality: All cause
2 Under 75 mortality: Circulatory
3 Under 75 mortality: Respiratory
4 Under 75 mortality: Cancer
5 Under 75 mortality: External causes
6 Under 75 mortality: Alcohol-related
7 Emergency Admissions
8 Disability: Activities limited 'a lot'
Health Risks/Behaviours
9 Smoking prevalence (modelled)
10 Physically inactive (modelled)
11 Childhood obesity - Year R
12 Childhood obesity - Year 6
13 Eat '5-a-day' fruit & veg (modelled)
14 Mental health prevalence (modelled)
15 Wellbeing: Low life satisfaction (modelled)
16 Wellbeing: Low 'things I do worthwhile' (modelled)
Wider Determinants
17 Median income (modelled)
18 Benefit claimants (out-of-work benefits)
19 Not school ready (Year R)
20 Do not achieve 5+ good GCSEs
21 No qualifications
22 Education, Training & Skills (IMD domain)
23 No car
24 Tenure: Social Rented
25 Tenure: Private Rented
26 Overcrowding
27 Shared dwellings
28 Transience: Moved in last year
29 Single parents
30 Distance to nearest GP
31 Distance to nearest pharmacy
32 Distance to nearest A&E/Urgent Care centre
33 Crime rate (per 1,000 population)
34 Living environment (IMD domain)
35 Deprivation (IMD)
0
1
2
3
4
5
6
7
8
Index (1=same as Kent)
Prepared by KPHO (RK), Jan 2016

This analysis highlights the following key characteristics of type 2 deprived areas in respect of some of the wider determinants of health, and in comparison with Kent as a whole:

- Low educational attainment and lack of qualifications
- Fewer out-of-work benefit claimants than other deprived groups
- Car ownership is high
- Lower crime rates than many other deprived areas
- Low levels of movement/transiency.

In terms of health risks and behaviours, type 2 deprived areas have:

- Lower smoking prevalence than other deprived area types
- Higher levels of wellbeing than other deprived area types.

In terms of health outcomes, type 2 deprived areas have:

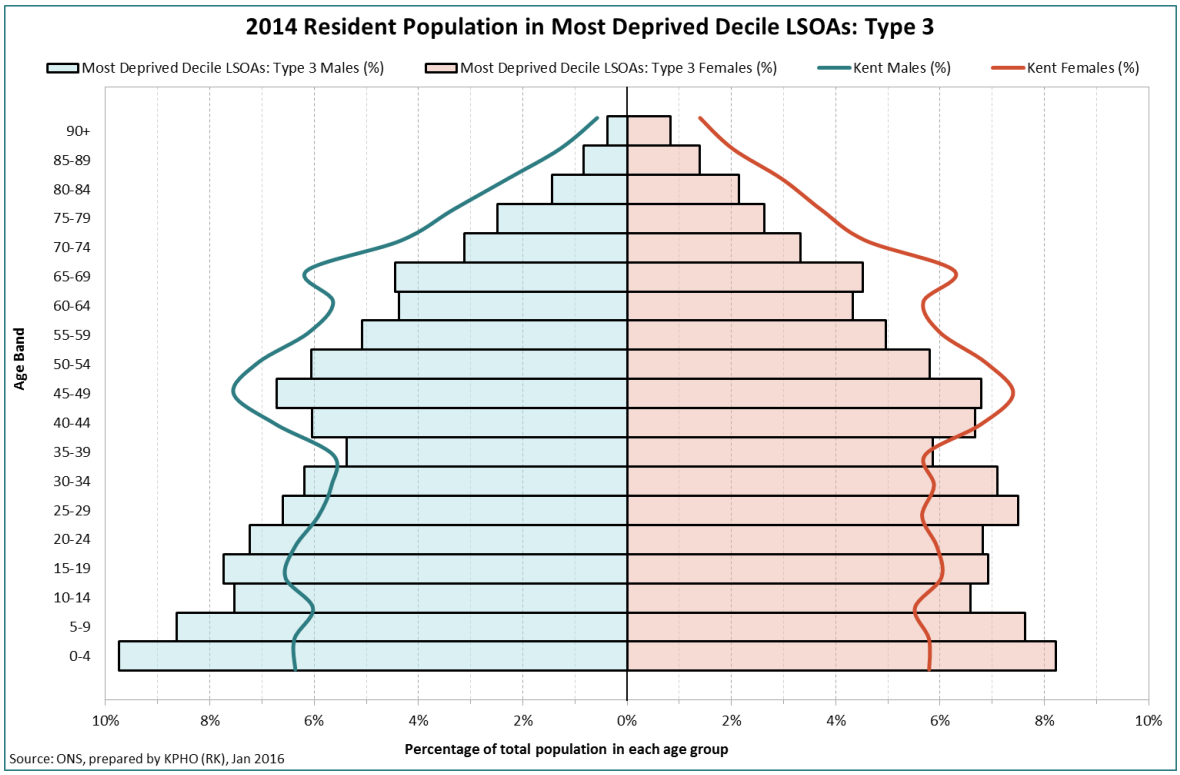
- Particularly high rates of disability ('activities limited a lot')
- High premature mortality.

Please see Appendix B for analysis of type 2 deprived areas at CCG-level, including detailed local maps for individual LSOAs falling into this cluster.

5.4 Type 3: Families in social housing

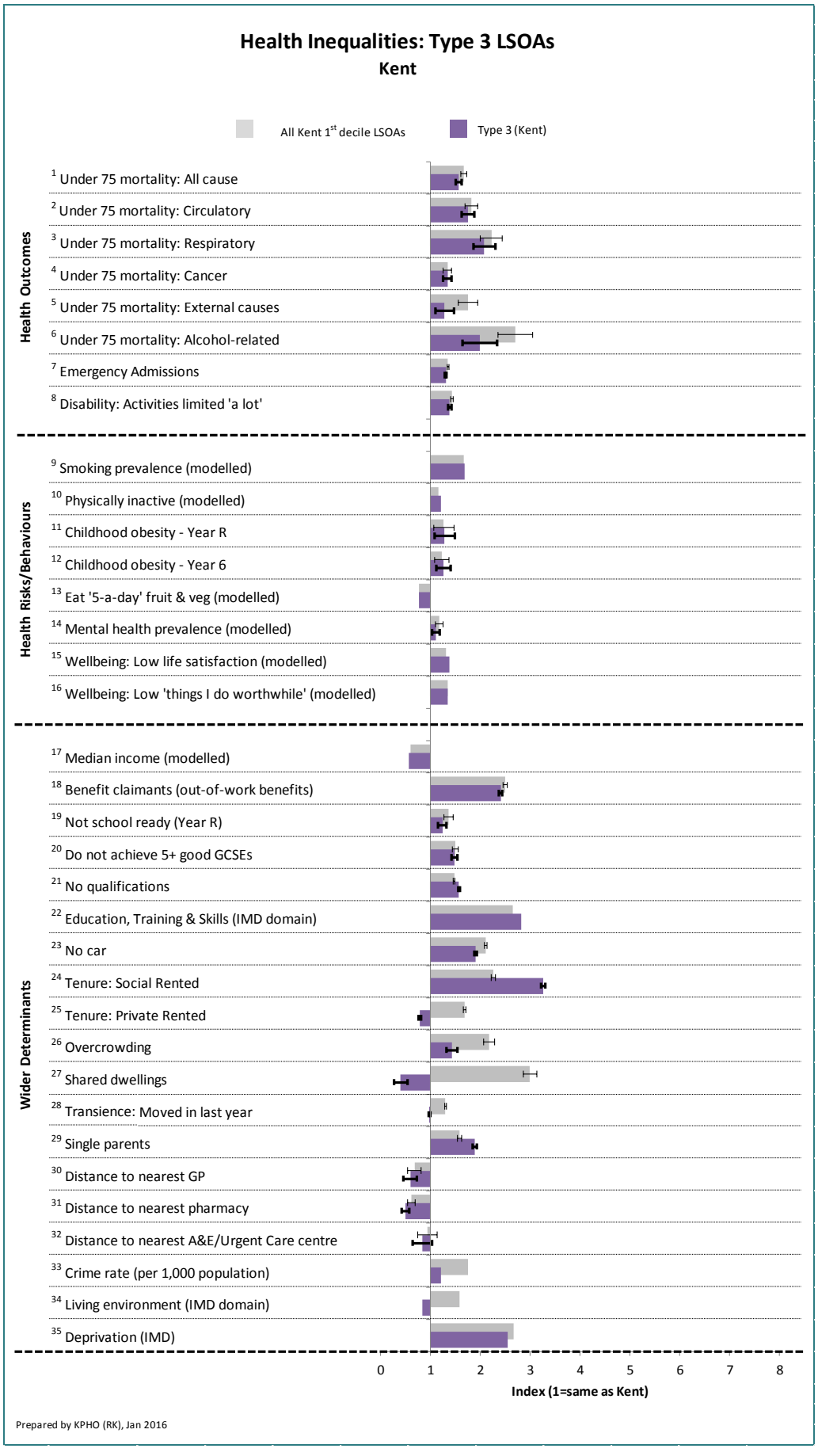
A total of 51 of the 88 most deprived decile LSOAs in Kent fall into type 3. This is the largest of the four deprivation types. These include LSOAs in Folkestone East, Aycliffe, Buckland Valley, St Radigans, Stanhope, Aylesford Green, Victoria, Davington Priory, Northgate, Gorrell, Seasalter, Wincheap, Swanley St Mary's, Dartford, Swanscombe, Kings Farm, Westcourt, Sheerness, Queenborough, Rushenden, Sittingbourne, Dane Valley, Garlinge, Newington, Parkwood, Shepway and Postley Road. For detailed local maps of the individual LSOAs falling into this cluster see the CCG-level summaries in Appendix B.

The chart below shows the age structure of the population of type 3 deprived areas in comparison with Kent as a whole.



This analysis shows that type 3 deprived areas have very high numbers children and lower numbers of over 50s in comparison with the Kent population as a whole.

The chart overleaf provides a summary of the characteristics of type 3 deprived areas in terms of health outcomes, health risks and behaviours, and the wider determinants of health. In this analysis type 3 deprived areas have been indexed against the average for Kent for each individual characteristic. Also shown is data for the most deprived decile as a whole.


Health Inequalities: Type 3 LSOAs
Kent
All Kent 1st decile LSOAs
Type 3 (Kent)
Health Outcomes
1 Under 75 mortality: All cause
2 Under 75 mortality: Circulatory
3 Under 75 mortality: Respiratory
4 Under 75 mortality: Cancer
5 Under 75 mortality: External causes
6 Under 75 mortality: Alcohol-related
7 Emergency Admissions
8 Disability: Activities limited 'a lot'
Health Risks/Behaviours
9 Smoking prevalence (modelled)
10 Physically inactive (modelled)
11 Childhood obesity - Year R
12 Childhood obesity - Year 6
13 Eat '5-a-day' fruit & veg (modelled)
14 Mental health prevalence (modelled)
15 Wellbeing: Low life satisfaction (modelled)
16 Wellbeing: Low 'things I do worthwhile' (modelled)
Wider Determinants
17 Median income (modelled)
18 Benefit claimants (out-of-work benefits)
19 Not school ready (Year R)
20 Do not achieve 5+ good GCSEs
21 No qualifications
22 Education, Training & Skills (IMD domain)
23 No car
24 Tenure: Social Rented
25 Tenure: Private Rented
26 Overcrowding
27 Shared dwellings
28 Transience: Moved in last year
29 Single parents
30 Distance to nearest GP
31 Distance to nearest pharmacy
32 Distance to nearest A&E/Urgent Care centre
33 Crime rate (per 1,000 population)
34 Living environment (IMD domain)
35 Deprivation (IMD)
0
1
2
3
4
5
6
7
8
Index (1=same as Kent)
Prepared by KPHO (RK), Jan 2016

Type 3 deprived areas are characterised by families with children in social housing.

This analysis highlights the following key characteristics of type 3 deprived areas in respect of some of the wider determinants of health, and in comparison with Kent as a whole:

- Low incomes
- Poor scores for education
- High numbers of out-of-work benefits claimants
- Particularly high number of single parents
- Better living environment and lower crime rates than other deprived areas.

In terms of health risks and behaviours, type 3 deprived areas have:

- High smoking prevalence
- Low levels of wellbeing.

In terms of health outcomes, type 3 deprived areas have:

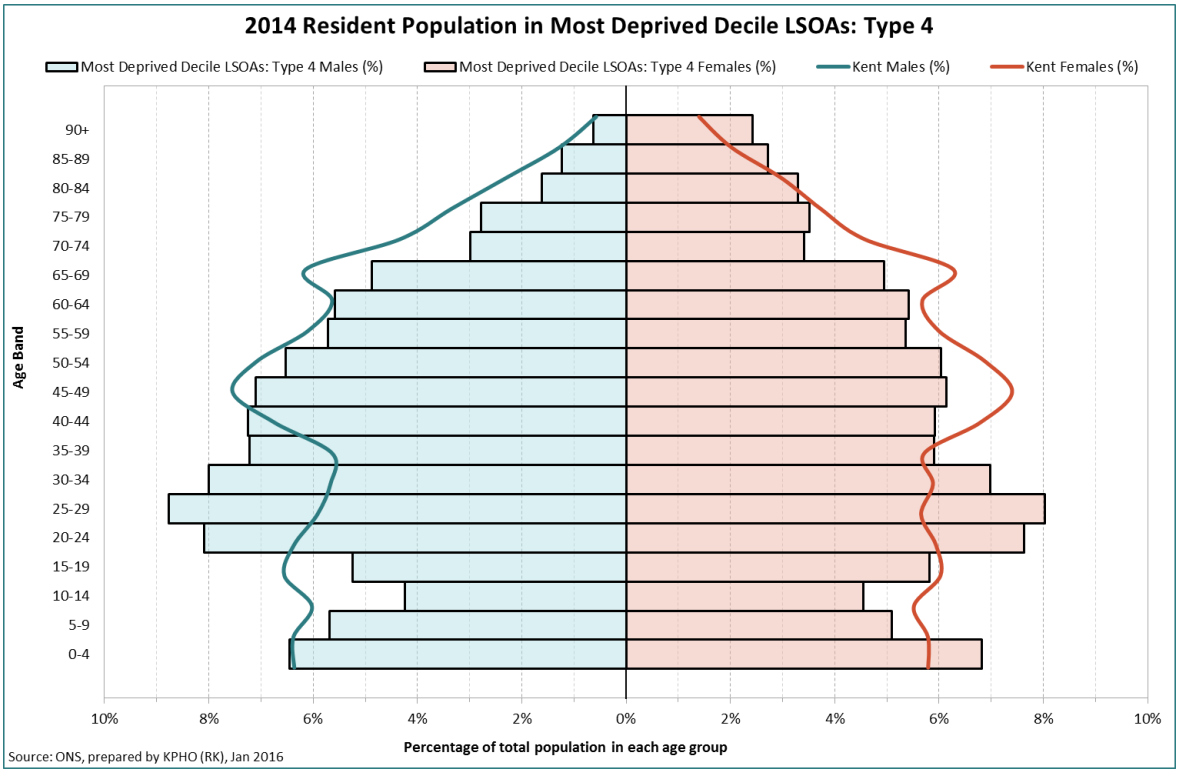
- High premature mortality rates
- High emergency hospital admission rates
- High rates of disability ('activities limited a lot').

Please see Appendix B for analysis of type 3 deprived areas at CCG-level, including detailed local maps for individual LSOAs falling into this cluster.

5.5 Type 4: Young people in poor quality accommodation

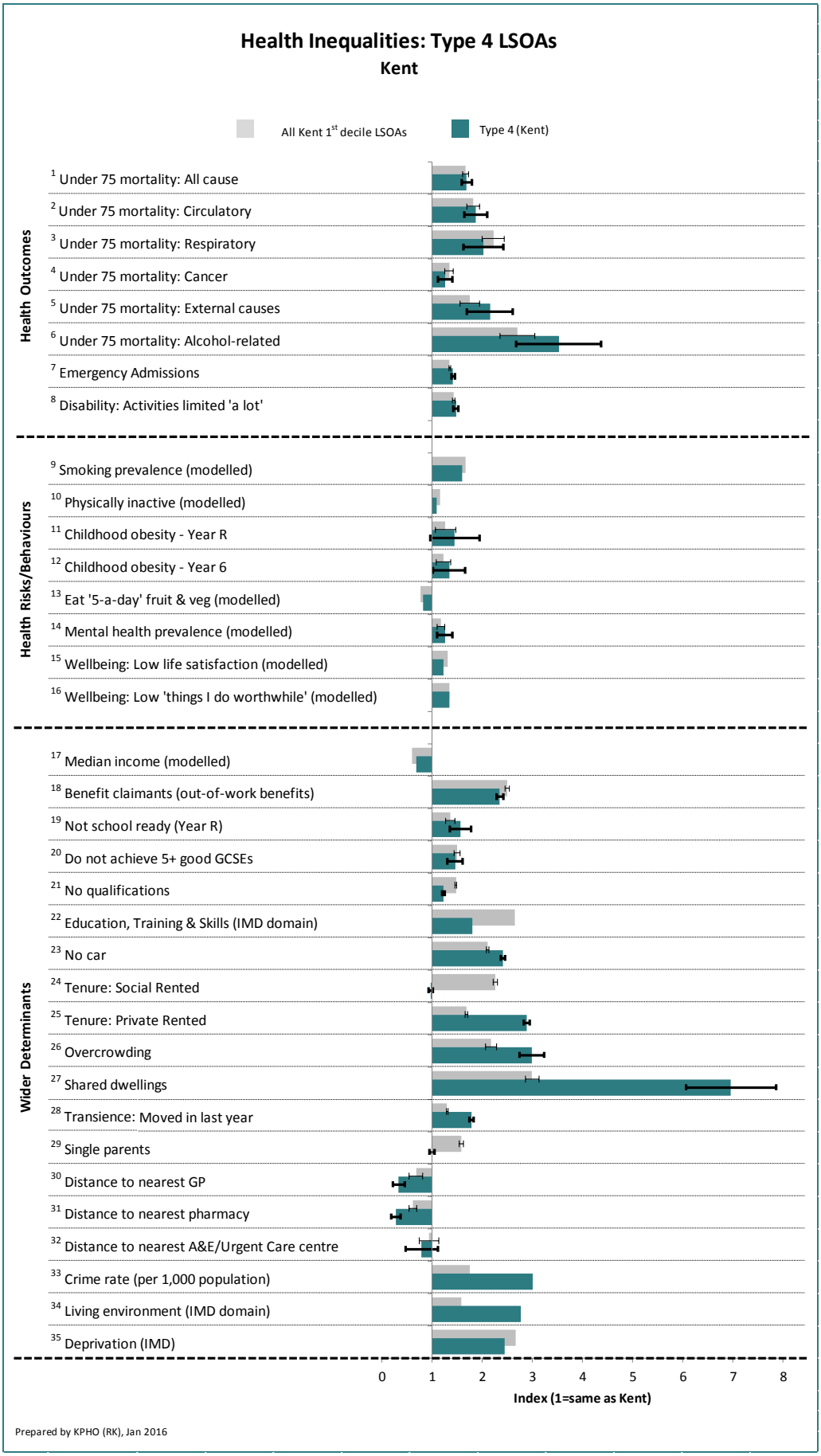
A total of 15 of the 88 most deprived decile LSOAs in Kent fall into type 4. These include LSOAs in Folkestone Harvey Central, Priory, Pencester, Heron, Herne Bay, Central Gravesend, Central Harbour (Ramsgate), Westbrook, Eastcliff and Cliftonville West. For detailed local maps of the individual LSOAs falling into this cluster see the CCG-level summaries in Appendix B.

The chart below shows the age structure of the population of type 4 deprived areas in comparison with Kent as a whole.



This analysis shows that type 4 deprived areas have high numbers of young adults and low numbers of school-age children and teenagers.

The chart overleaf provides a summary of the characteristics of type 4 deprived areas in terms of health outcomes, health risks and behaviours, and the wider determinants of health. In this analysis type 4 deprived areas have been indexed against the average for Kent for each individual characteristic. Also shown is data for the most deprived decile as a whole.


Health Inequalities: Type 4 LSOAs
Kent
All Kent 1st decile LSOAs
Type 4 (Kent)
Health Outcomes
1 Under 75 mortality: All cause
2 Under 75 mortality: Circulatory
3 Under 75 mortality: Respiratory
4 Under 75 mortality: Cancer
5 Under 75 mortality: External causes
6 Under 75 mortality: Alcohol-related
7 Emergency Admissions
8 Disability: Activities limited 'a lot'
Health Risks/Behaviours
9 Smoking prevalence (modelled)
10 Physically inactive (modelled)
11 Childhood obesity - Year R
12 Childhood obesity - Year 6
13 Eat '5-a-day' fruit & veg (modelled)
14 Mental health prevalence (modelled)
15 Wellbeing: Low life satisfaction (modelled)
16 Wellbeing: Low 'things I do worthwhile' (modelled)
Wider Determinants
17 Median income (modelled)
18 Benefit claimants (out-of-work benefits)
19 Not school ready (Year R)
20 Do not achieve 5+ good GCSEs
21 No qualifications
22 Education, Training & Skills (IMD domain)
23 No car
24 Tenure: Social Rented
25 Tenure: Private Rented
26 Overcrowding
27 Shared dwellings
28 Transience: Moved in last year
29 Single parents
30 Distance to nearest GP
31 Distance to nearest pharmacy
32 Distance to nearest A&E/Urgent Care centre
33 Crime rate (per 1,000 population)
34 Living environment (IMD domain)
35 Deprivation (IMD)
0 1 2 3 4 5 6 7 8
Index (1=same as Kent)
Prepared by KPHO (RK), Jan 2016

Type 4 deprived areas have a number of similar characteristics to type 1 deprived areas, including having high numbers of young adults in private rented accommodation.

This analysis highlights the following key characteristics of type 4 deprived areas in respect of some of the wider determinants of health, and in comparison with Kent as a whole:

- High levels of shared dwellings and overcrowding
- Better educated than the other deprivation types
- Particularly poor living environment with high crime rates
- Low incomes, but not as low as Type 1 areas
- High levels of out-of-work benefit claimants, but not as high has Type 1 areas
- Particularly high levels of movement/transiency.

In terms of health risks and behaviours, type 4 deprived areas have:

- High smoking prevalence.

In terms of health outcomes, type 4 deprived areas have:

- High premature mortality rates
- High emergency hospital admission rates
- High rates of disability ('activities limited a lot').

Please see Appendix B for analysis of type 4 deprived areas at CCG-level, including detailed local maps for individual LSOAs falling into this cluster.

Appendix A: Data sources

The charts in Section 5 summarising the characteristics of each deprivation type in terms of health outcomes, health risks and behaviours, and the wider determinants of health show data derived from the following sources:

1-6	Age-standardised mortality rates, 2006-2014. Source: PCMD. **2** ICD10: I00-I99. **3** ICD10: J00-J99. **4** ICD10: C00-C97. **5** ICD10: U00-Y99. **6** ICD10: F10, G31.2, G62.1, I42.6, K29.2, K70, K73, K74, K86.0, X45, X65, Y15.
7	Emergency admissions, 2012/13-2013/14. Source: SUS.
8	% self-reporting day-to-day activities 'limited a lot', 2011. Source: Census.
9	Modelled based on smoking prevalence data by Mosaic type. Source: Experian (TGI: 'Heavy', 'Medium' & 'Light' smokers combined).
10	Modelled based on % who do not exercise by Mosaic type. Source: Experian (TGI).
11-12	% children measured who were obese, 2013/14. Source: NCMP.
13	Modelled based on % who claim to eat '5-a-day' fruit and vegetables by Mosaic type. Source: Experian (TGI).
14	Modelled mental health prevalence based on GP practice-level data, 2014/15. Source: QOF.
15-16	Modelled wellbeing based on ONS Annual Population Survey (APS) data by Acorn type, 2011/12. Source: DCLG. **15** % scoring 0-6 for 'Overall, how satisfied are you with your life nowadays?' **16** % scoring 0-6 for 'Overall, to what extent do you feel the things you do in your life are worthwhile?'
17	Modelled based on median household income data by Mosaic type. Source: Experian (ConsumerView).
18	% claiming out of work benefits (defined as all those aged 16-64 who are jobseekers, claiming ESA & incapacity benefits, lone parents claiming Income Support and others on income related benefits), February 2015. Source: DWP (from Nomis).
19	% Year R pupils not achieving a good level of development, 2015. Source: KCC, MIU.

20 % pupils not achieving 5+ A*-C GCSEs (including English & Maths) at the end of Key Stage 4, 2015. Source: KCC, MIU.

21 % with no qualifications (based on persons aged 16+), 2011. Source: Census.

22 Education, Training & Skills IMD domain (average score), 2015. Source: DCLG.

23 % of households with no car or van, 2011. Source: Census.

24 % of households living in social rented accommodation, 2011. Source: Census.

25 % of households living in private rented accommodation, 2011. Source: Census.

26 % of households with an occupancy rating of -2 (i.e. with 2 too few rooms), 2011. Source: Census.

27 % of households with accommodation type 'shared dwellings', 2011. Source: Census.

28 % of households not living at the same address a year ago, 2011. Source: Census. Please note that OAs E00124937 & E00166800 have been removed from this analysis due to the undue influence of Eastchurch prison on levels of transience.

29 % of households with no adults or one adult and one or more children, 2011. Source: Census.

30-32 Distance to nearest GP/pharmacy/A&E or Urgent Care centre (in miles, as the crow flies from population weighted centroid of LSOA), 2015. Source: KCC Business Intelligence.

33 Crime rate (recorded crime per 1,000 population), Oct 2013 - Sept 2015. Source: data.police.uk.

34 Living Environment IMD domain (average score), 2015. Source: DCLG.

35 Index of Multiple Deprivation (IMD) (average score), 2015. Source: DCLG.

For some of the variables above, modelling techniques have been used to derive LSOA-level estimates for use in the analysis.

QOF Prevalence Modelling

Modelled estimates of recorded disease prevalence at LSOA-level have been produced using GP registration data extracted from HSCIC's maintained GP Payments system[12].

Disease prevalence estimates have been produced at LSOA-level by combining the numbers of people in each LSOA registered with each individual GP practice with that GP's disease prevalence rates (as recorded in the 2014/15 QOF). Thus, the model relies on the assumption that disease prevalence rates for the whole GP practice apply to the patients registered to that GP who live in the LSOA in question. This should be borne in mind when interpreting the results.

Mosaic Modelling

Experian's Mosaic classification system has been used to produce modelled estimates for smoking prevalence, physical inactivity, consumption of fruit and vegetables, and income.

Taking smoking as an example, prevalence estimates have been produced at LSOA-level by combining the Mosaic type-level population profile of each individual LSOA with smoking rates for each Mosaic type (as contained within the Mosaic Grand Index). Thus, the model relies on the assumption that smoking rates for a given Mosaic type, calculated by Experian at national level, apply to people of that Mosaic type within Kent.

[12] http://www.hscic.gov.uk/article/2021/Website-Search?productid=19077&q=Numbers+of+Patients+Registered+at+a+GP+Practice&sort=Relevance&size=10&page=1&area=both#top

Appendix B: CCG-level summaries

CCG-level summaries, including detailed local maps.

Ashford Profile.pdf
C&C Profile.pdf
DGS Profile.pdf
South Kent Coast Profile.pdf
Swale Profile.pdf
Thanet Profile.pdf
West Kent Profile.pdf

Appendix C: Deprivation types by LSOA

Data file detailing deprivation types by LSOA.

Appendix C.xlsx

KENT PUBLIC HEALTH OBSERVATORY

SOUTH KENT COAST CCG

Analysis of Deprived Areas

In the most deprived decile for Kent

January 2016

KCC Public Health is taking a new approach to reducing health inequalities in the county, by producing focussed analysis of LSOAs in the most deprived decile. Multivariate segmentation techniques have been used to identify different 'types' of deprivation in Kent. This report shows our analysis of the most deprived areas in the South Kent Coast CCG Area. For more information on the rationale of this approach and our methods, please see the full report.

Produced by

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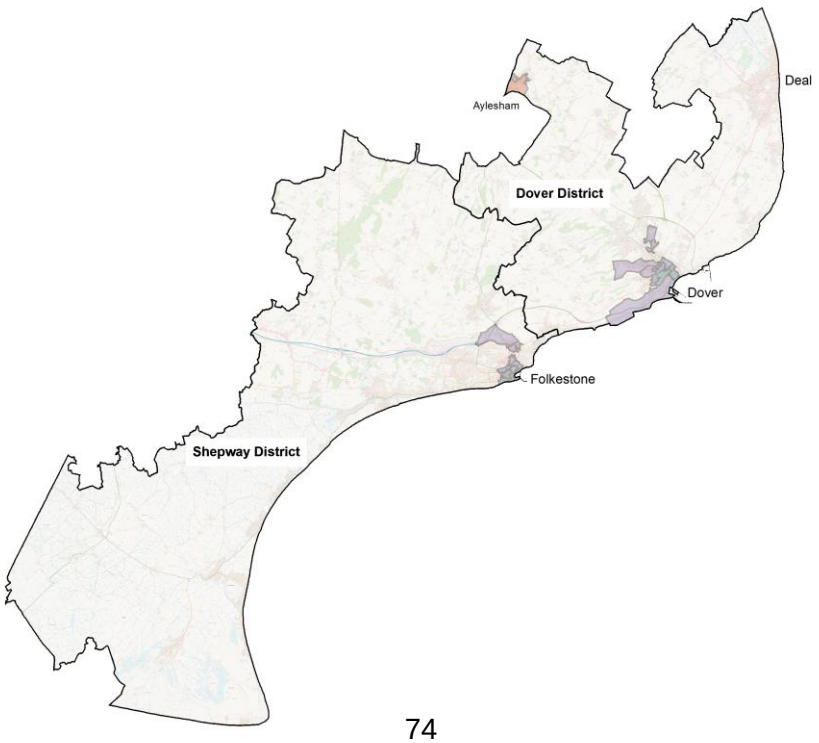
Kent County Council kent.gov.uk

Background

South Kent Coast CCG covers the areas of Shepway and Dover, which include the main towns of Folkestone and Dover respectively. Deprivation statistics are higher than the Kent average and the England average, with generally worse health outcomes. The towns have an important location on the South Coast of England, with major transport routes between mainland Europe and London. 19 LSOAs feature in the most deprived decile for deprivation in Kent, 8 in Shepway (around Folkestone) and 11 in Dover (around Dover town). There is another pocket of deprivation in the village of Aylesham.

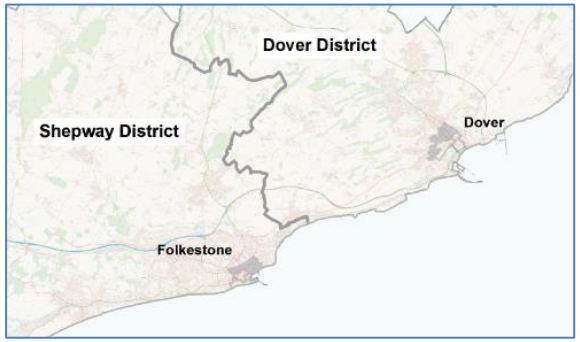
Deprived Areas

Ward Code	Ward Name	LSOA Code	LSOA name	LSOA rank	GP practice codes serving LSOA					Type
E05004943	Aylesham	**E01024192**	**Dover 006C**	**88**	G82211					2
E05004944	Buckland	**E01024196**	**Dover 011D**	**48**	G82015	G82117	G82002	G82128		3
		E01024193	**Dover 011A**	**72**	G82015	G82002	G82128	G82117		3
E05004946	Castle	**E01033211**	**Dover 012F**	**32**	G82015	G82662	G82002			4
E05004951	Maxton, Elms Vale and Priory	**E01024215**	**Dover 013B**	**37**	G82729	G82015	G82662	G82128		4
		E01024214	**Dover 013A**	**70**	G82729	G82015				1
E05004958	St Radigunds	**E01024240**	**Dover 011F**	**24**	G82015	G82128	G82117	G82002		3
E05004960	Tower Hamlets	**E01024247**	**Dover 012D**	**58**	G82662	G82015	G82002	G82117	G82128	1
		E01024246	**Dover 013D**	**71**	G82117	G82128	G82015	G82002		1
		E01024248	**Dover 011H**	**81**	G82015	G82128	G82117	G82002		3
E05004961	Town and Pier	**E01024249**	**Dover 013E**	**74**	G82015	G82002	G82128			3
E05005037	Folkestone East	**E01024498**	**Shepway 003C**	**26**	G82086					3
		E01024496	**Shepway 003A**	**83**	G82086	G82091	G82232	G82187		3
E05005038	Folkestone Foord	**E01024500**	**Shepway 004B**	**86**	G82086					3
E05005039	Folkestone Harbour	**E01024504**	**Shepway 014A**	**12**	G82091	G82187				1
		E01024505	**Shepway 004E**	**68**	G82187	G82091	G82086			1
E05005040	Folkestone Harvey Central	**E01024507**	**Shepway 014B**	**23**	G82091	G82232				1
		E01033215	**Shepway 014D**	**49**	G82232	G82091				4
		E01033212	**Shepway 014C**	**53**	**G82091**	**G82232**				**4**



South Kent Coast CCG
Type 1 Deprived LSOAs
Folkestone Harbour, Clarendon, Tower Hamlets

Young people lacking opportunities



MAIN ISSUES

Characteristics

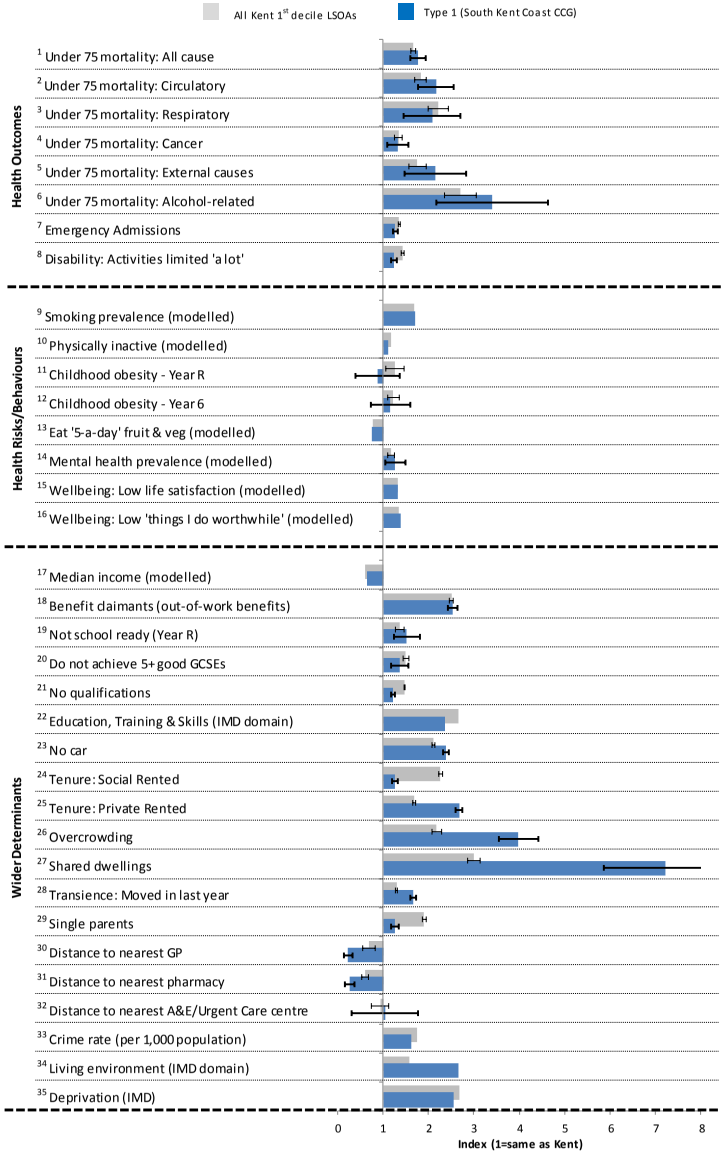
- Young adults in private rented accommodation
- Particularly high levels of shared dwellings and overcrowding
- Particularly poor living environment with high crime rates
- Low incomes
- High levels of out-of-work benefit claimants
- Poor scores for education
- Particularly high levels of movement/ transiency

Health Risks/Behaviours

- High smoking prevalence
- Low levels of wellbeing

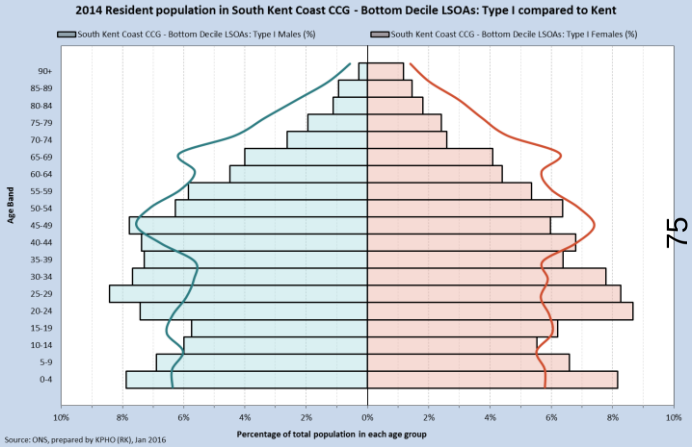
Health Outcomes

- High premature mortality rates
- Alcohol-related premature mortality and from 'external causes' particularly high



Prepared by KPHO (RK), Jan 2016

POPULATION DISTRIBUTION

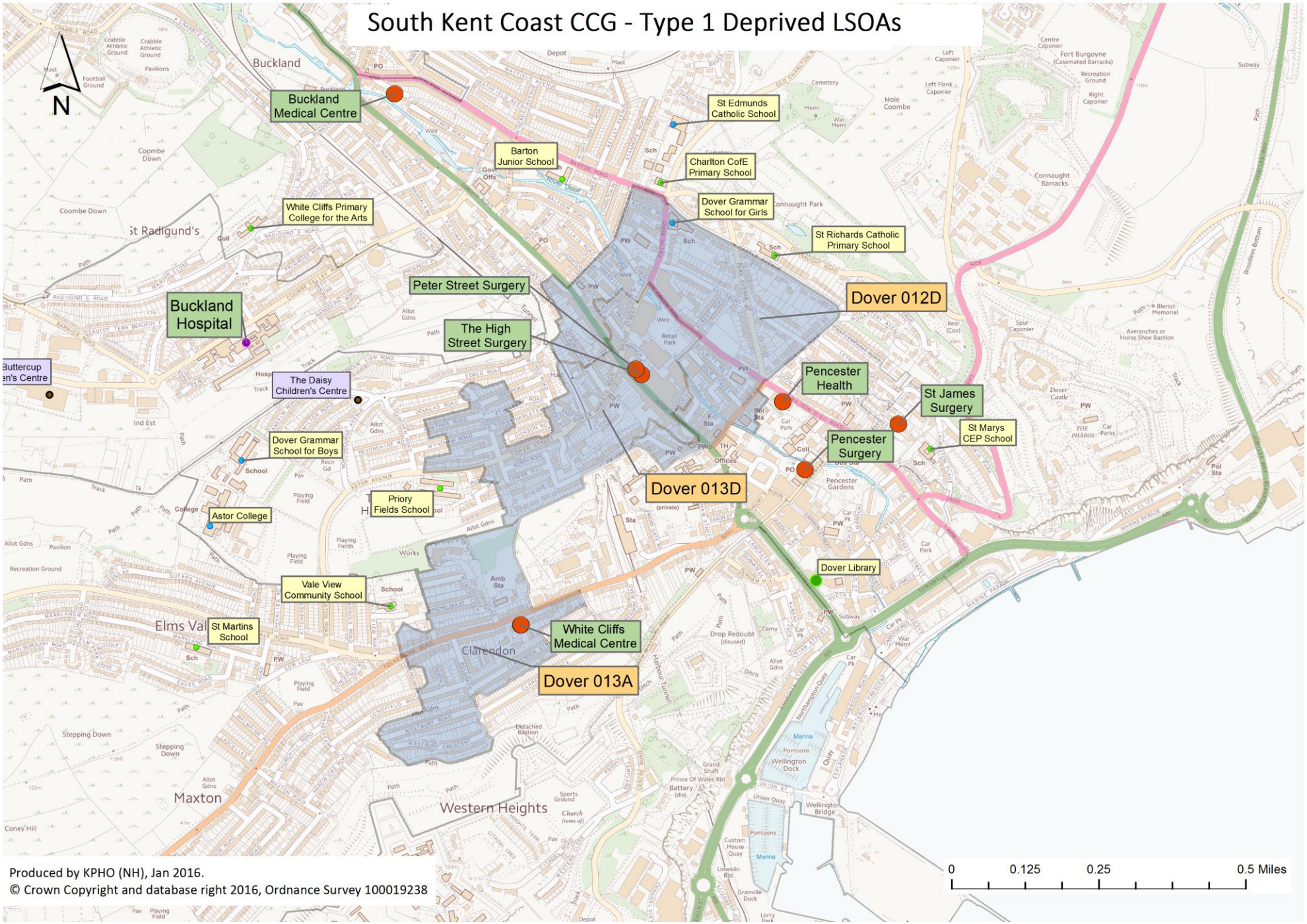


- High numbers of young adults and young children

KEY FOCUS AREAS:

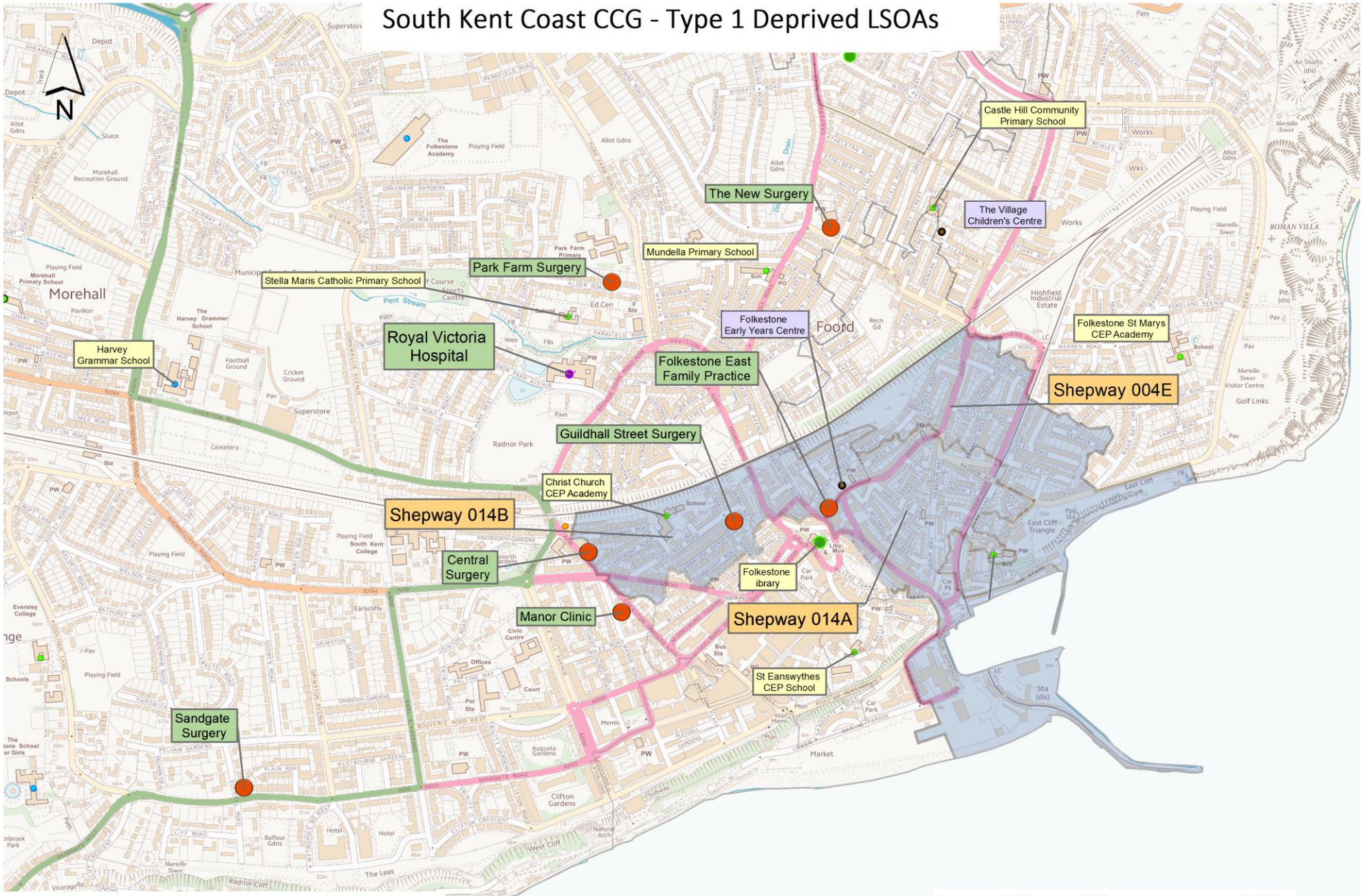
Education and employment opportunities for young people

South Kent Coast CCG - Type 1 Deprived LSOAs



Produced by KPHO (NH), Jan 2016.

South Kent Coast CCG - Type 1 Deprived LSOAs



Produced by KPHO (NH), Jan 2016.

Deprived rural households

South Kent Coast CCG
Type 2 Deprived LSOAs
Aylesham

MAIN ISSUES

**Please note that this analysis is based on a single LSOA, meaning wide confidence intervals for some measures.*

Characteristics

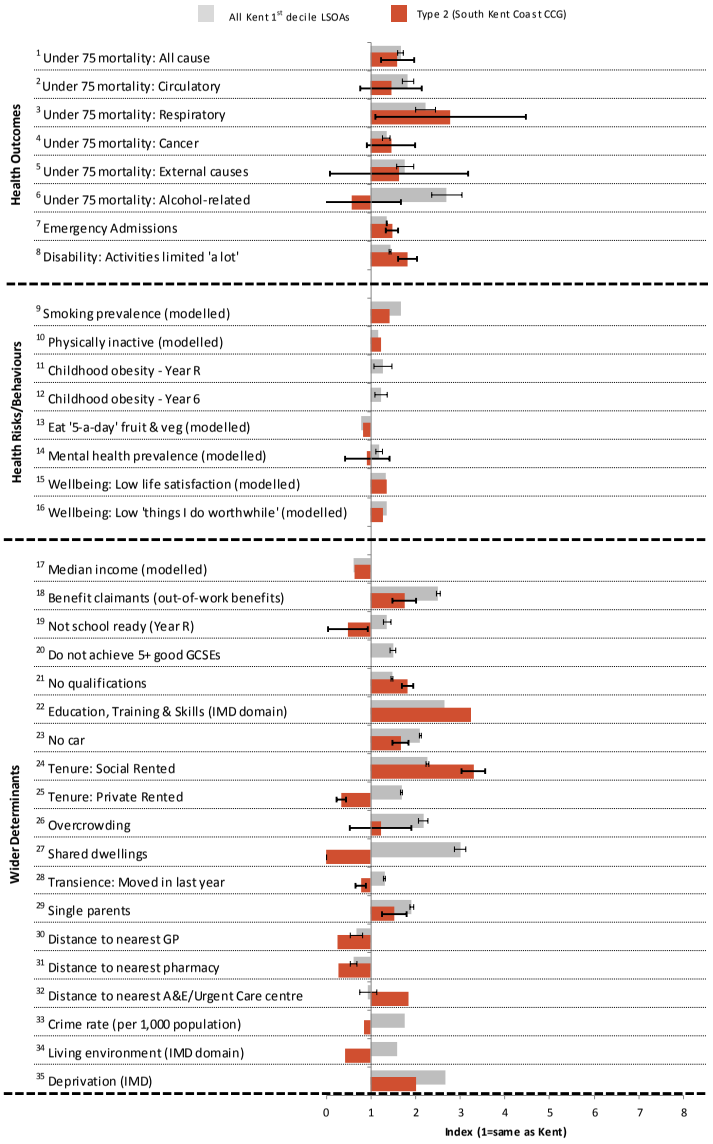
- Low educational attainment and lack of qualifications
- Fewer out-of-work benefit claimants than other deprived groups
- Car ownership is higher than for other deprivation types
- Better living environment and lower crime rates than many other deprived areas
- Low levels of movement/transiency

Health Risks/Behaviours

- Fairly high smoking prevalence
- Low levels of wellbeing

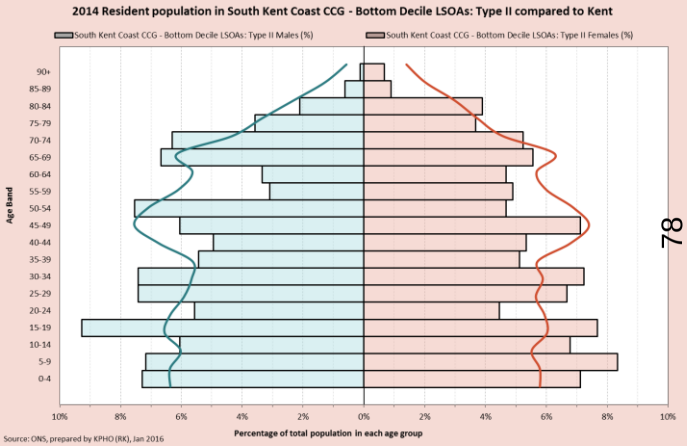
Health Outcomes

- Particularly high rates of disability ('activities limited a lot')
- High premature mortality



Prepared by KPHO(RK), Jan 2016

POPULATION DISTRIBUTION

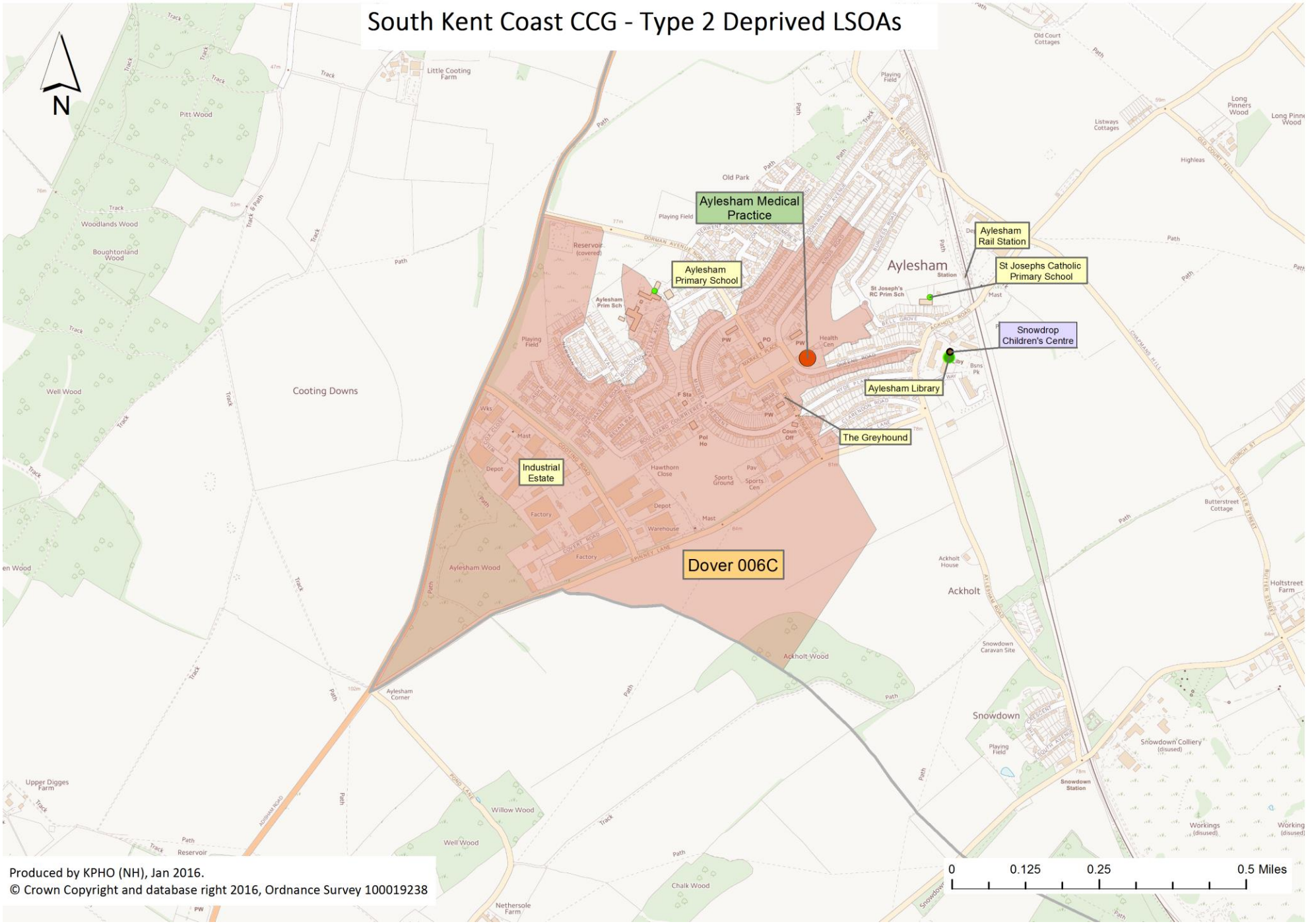


- Low population size makes comment on the population pyramid difficult

KEY FOCUS AREAS:

Education and qualifications

South Kent Coast CCG - Type 2 Deprived LSOAs



South Kent Coast CCG
Type 3 Deprived LSOAs
Folkestone East, Aycliffe, Buckland Valley, St Radigans

Families in social housing

MAIN ISSUES

Characteristics

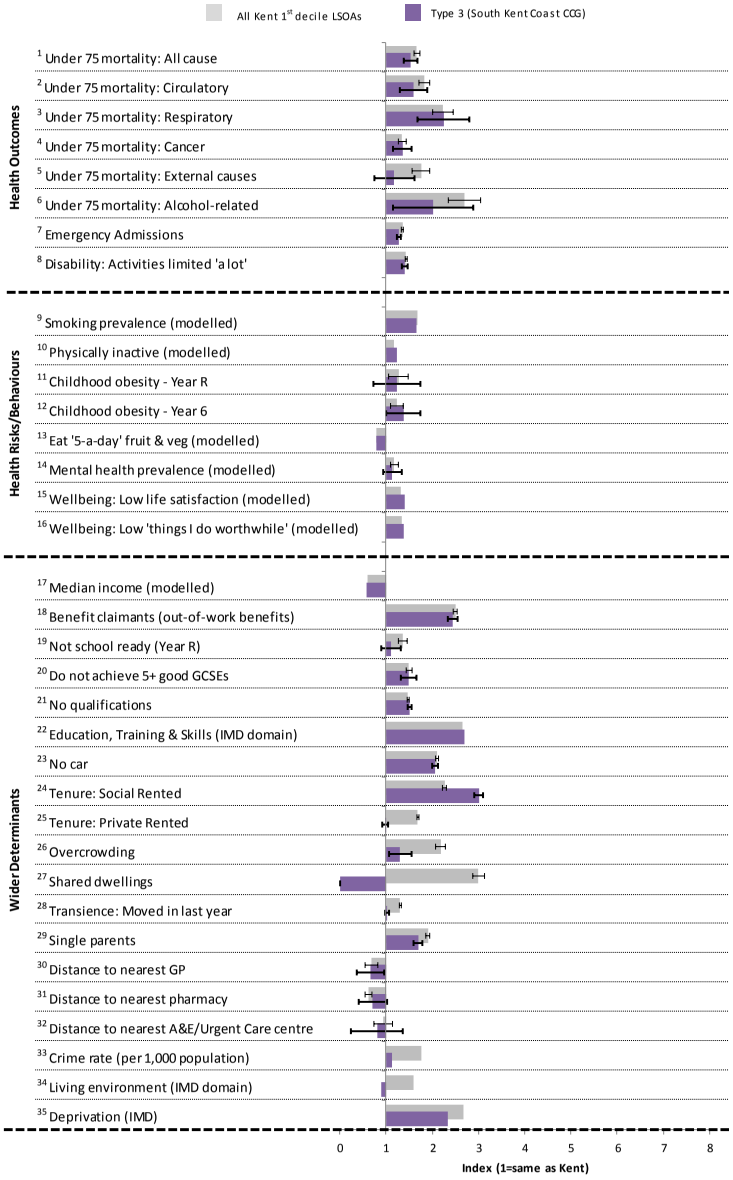
- Families with children in social housing
- Low incomes
- Poor scores for education
- High number of single parents
- Better living environment and lower crime rates than other deprived areas

Health Risks/Behaviours

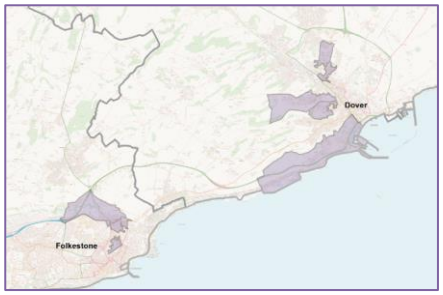
- High smoking prevalence
- Low levels of wellbeing

Health Outcomes

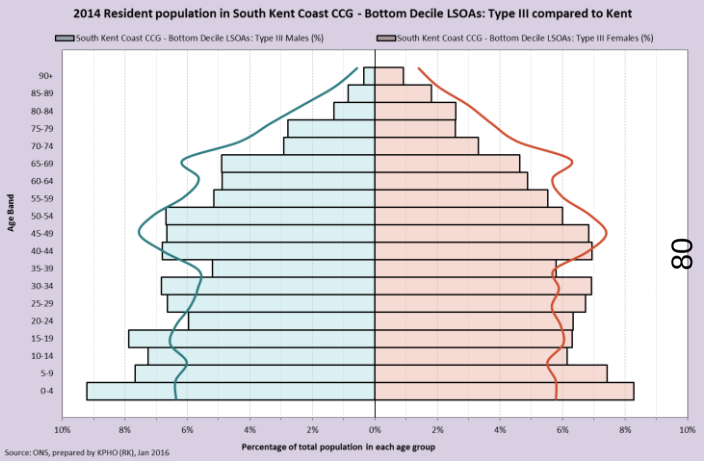
- High premature mortality rates
- High emergency hospital admission rates
- High rates of disability (‘activities limited a lot’)



Prepared by KPHO(RK), Jan 2016



POPULATION DISTRIBUTION

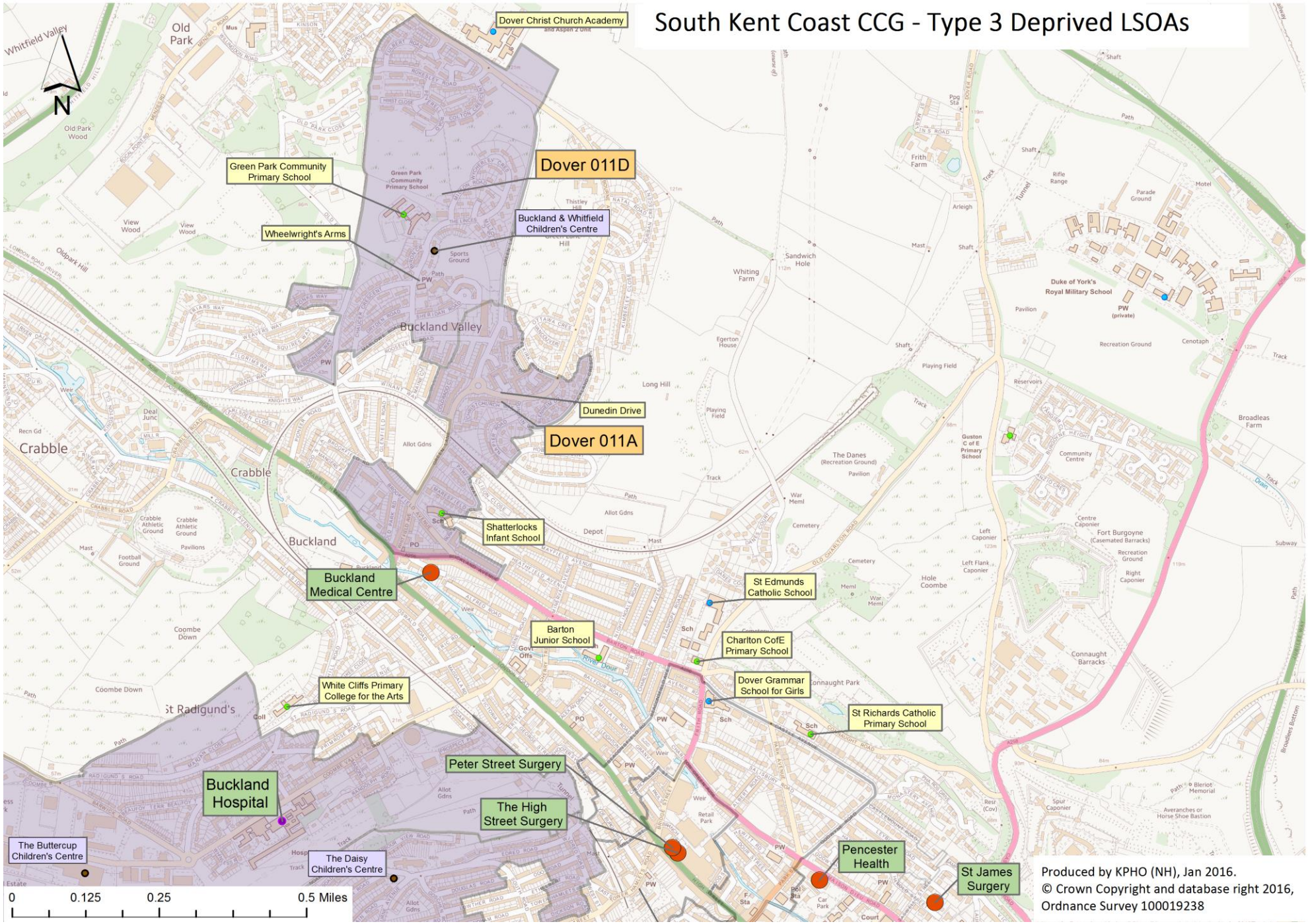


- High numbers of children
- Slightly higher numbers of young adults
- Slightly lower numbers of over 50s

KEY FOCUS AREAS:

Training, qualifications and employment for parents

child health and education


South Kent Coast CCG - Type 3 Deprived LSOAs
Dover Christ Church Academy
Green Park Community Primary School
Dover 011D
Buckland & Whitfield Children's Centre
Wheelwright's Arms
Buckland Valley
Dunedin Drive
Dover 011A
Shatterlocks Infant School
Buckland Medical Centre
St Edmunds Catholic School
Barton Junior School
Charlton CofE Primary School
White Cliffs Primary College for the Arts
Dover Grammar School for Girls
St Richards Catholic Primary School
Peter Street Surgery
Buckland Hospital
The High Street Surgery
The Buttercup Children's Centre
The Daisy Children's Centre
Pencester Health
St James Surgery
Crabble
Buckland
St Radigund's
Old Park
Whitfield Valley
Duke of York's Royal Military School
0
0.125
0.25
0.5 Miles
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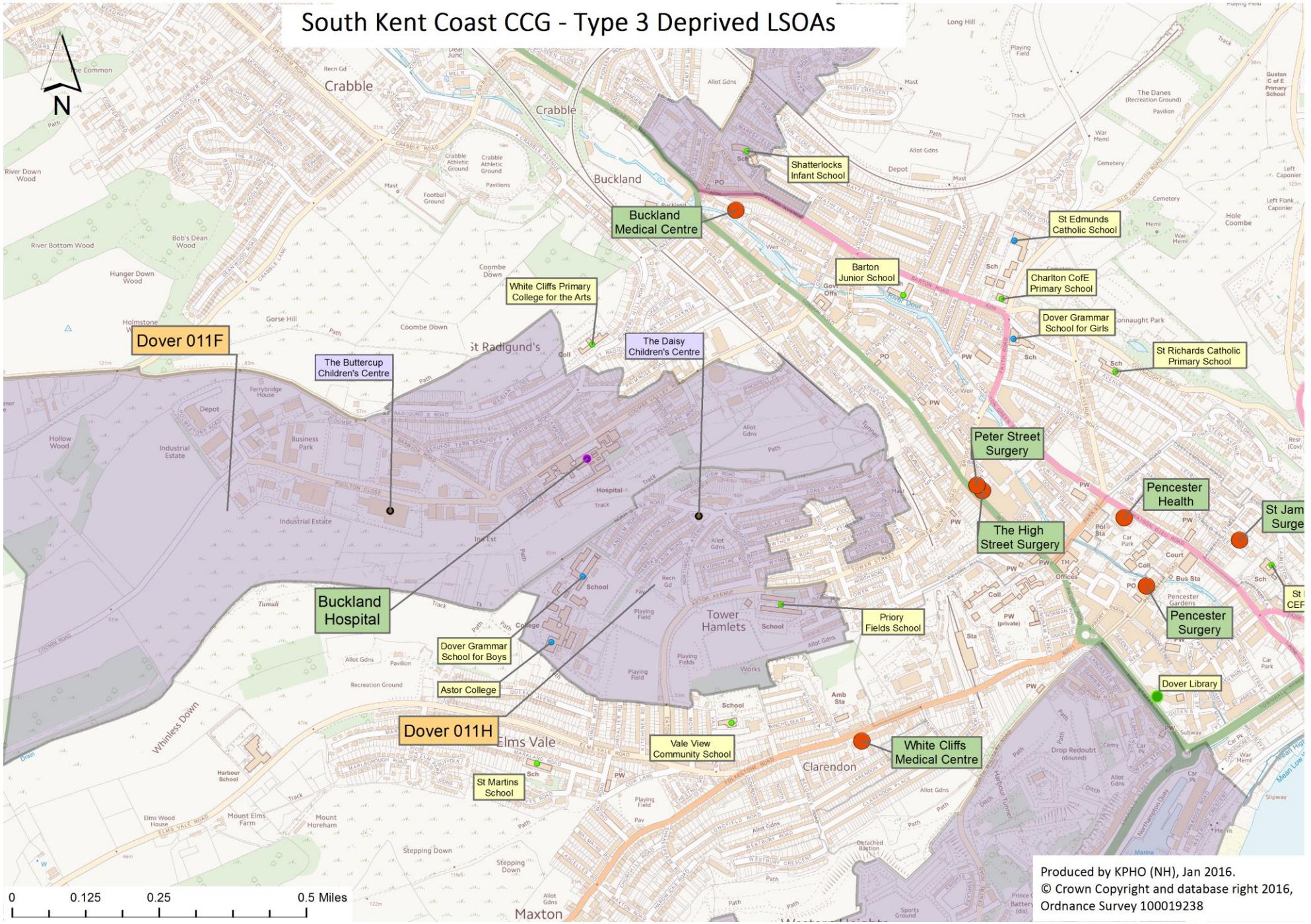
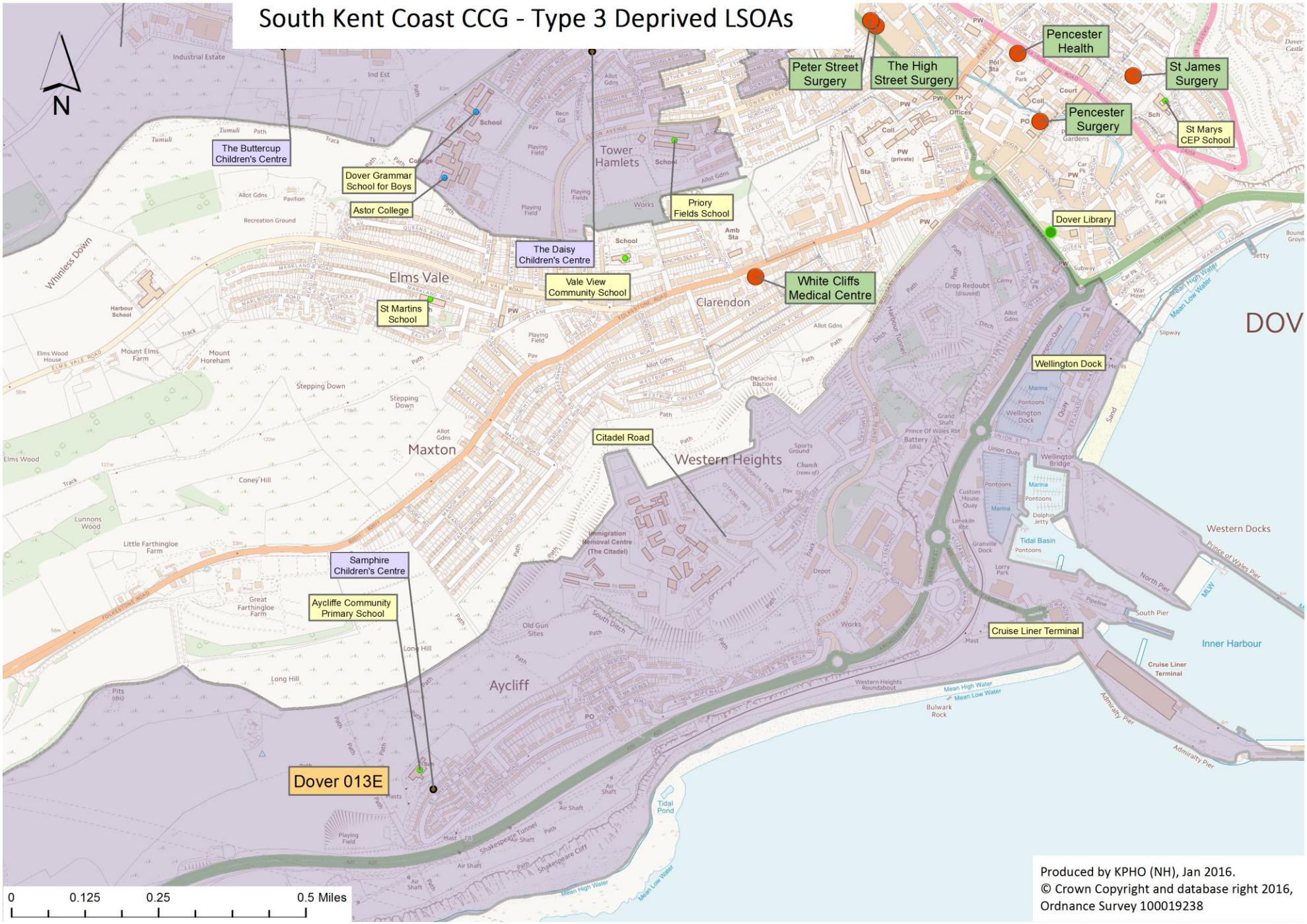
South Kent Coast CCG - Type 3 Deprived LSOAs



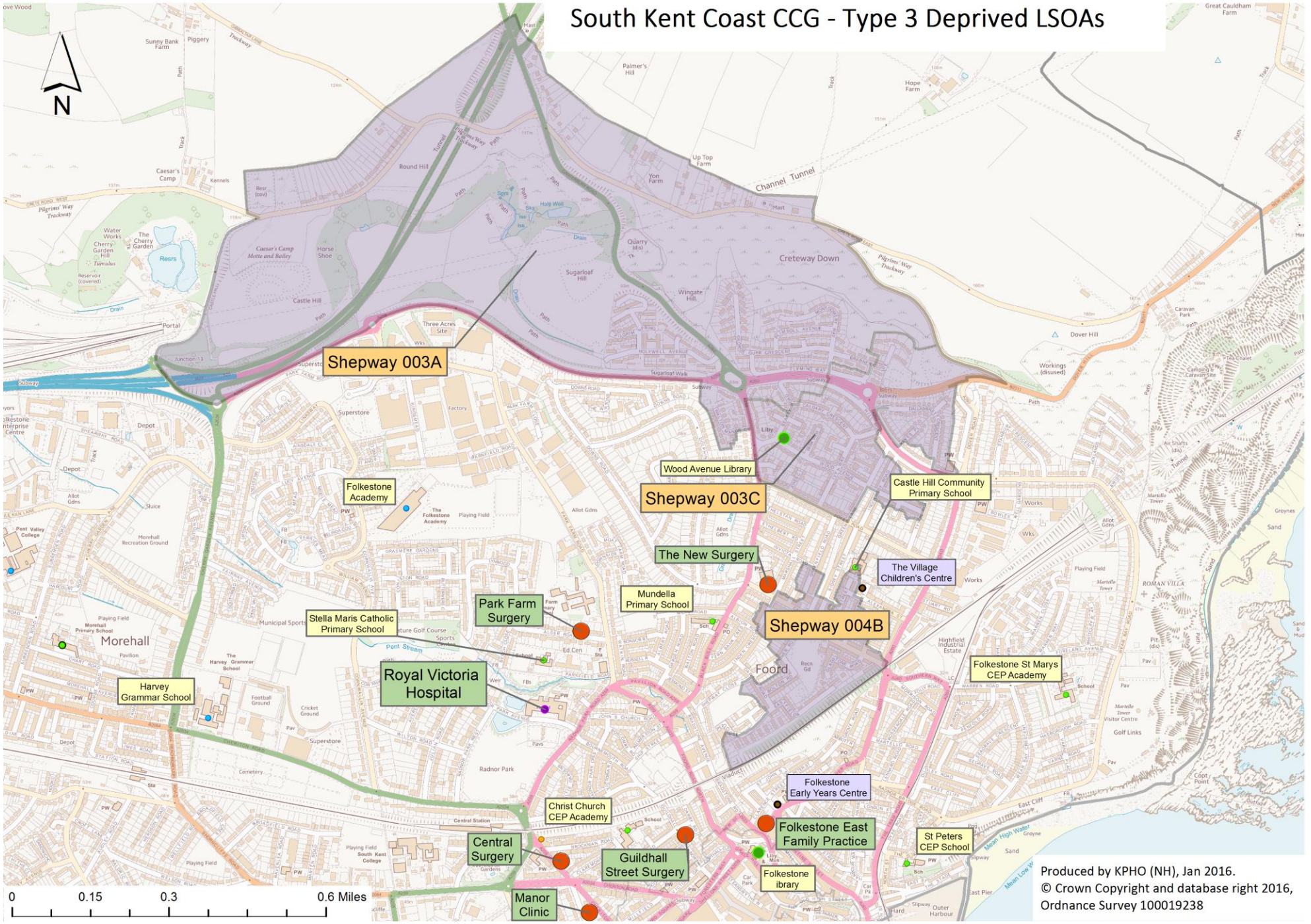
Produced by KPHO (NH), Jan 2016.

South Kent Coast CCG - Type 3 Deprived LSOAs



Produced by KPHO (NH), Jan 2016.

South Kent Coast CCG - Type 3 Deprived LSOAs



Produced by KPHO (NH), Jan 2016.

South Kent Coast CCG
Type 4 Deprived LSOAs
Folkestone Harvey Central, Priory, Pencester

Young people in poor quality accommodation

MAIN ISSUES

Characteristics

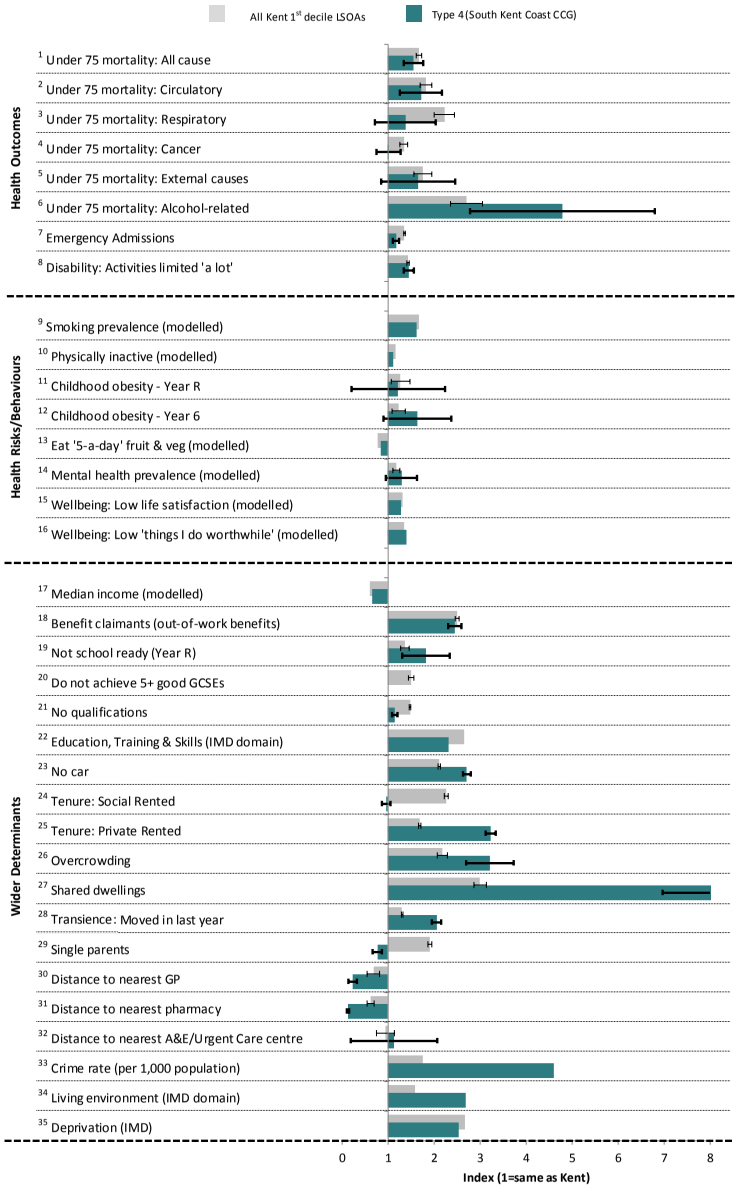
- Young adults in private rented accommodation
- Particularly high levels of shared dwellings and overcrowding
- Better educated than other deprived types
- Particularly poor living environment with particularly high crime rates
- High levels of out-of-work benefit claimants
- Particularly high levels of movement/ transiency

Health Risks/Behaviours

- High smoking prevalence
- Low levels of wellbeing

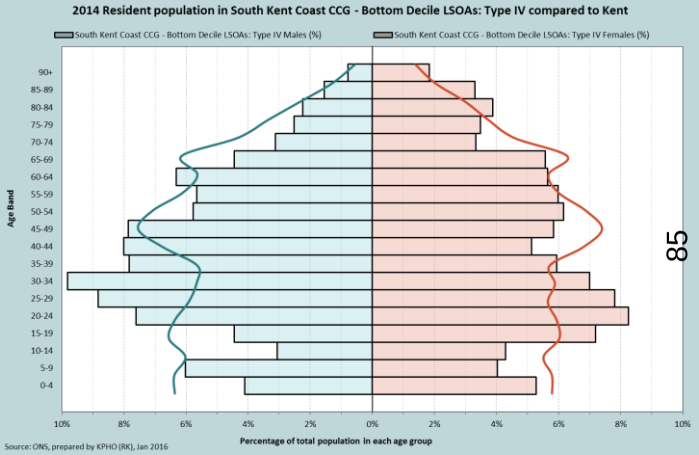
Health Outcomes

- High premature mortality rates
- High rates of disability ('activities limited a lot')



Prepared by KPHO (RK), Jan 2016

POPULATION DISTRIBUTION

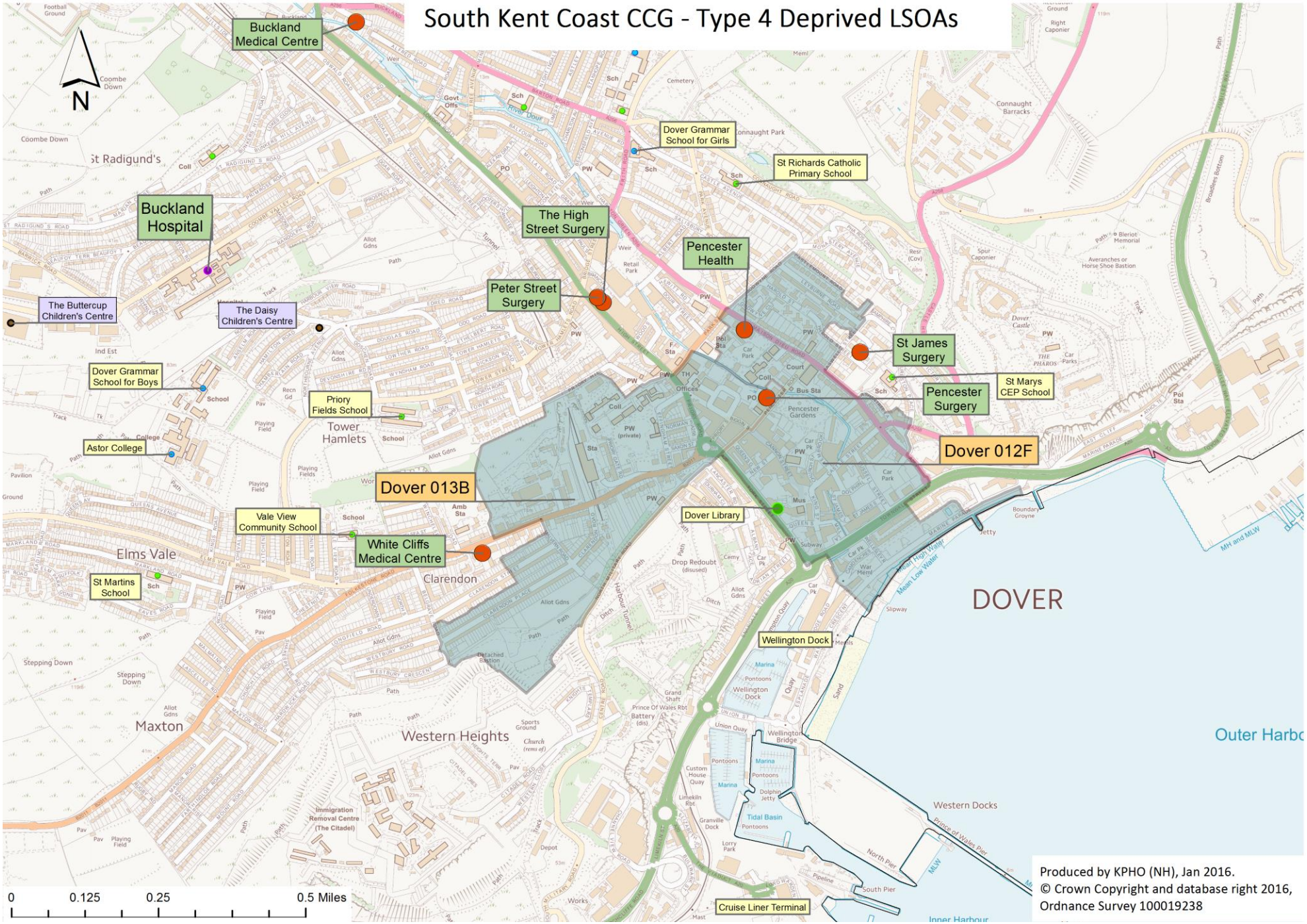


- High numbers of young adults
- Low numbers of children and teenagers

KEY FOCUS AREAS:

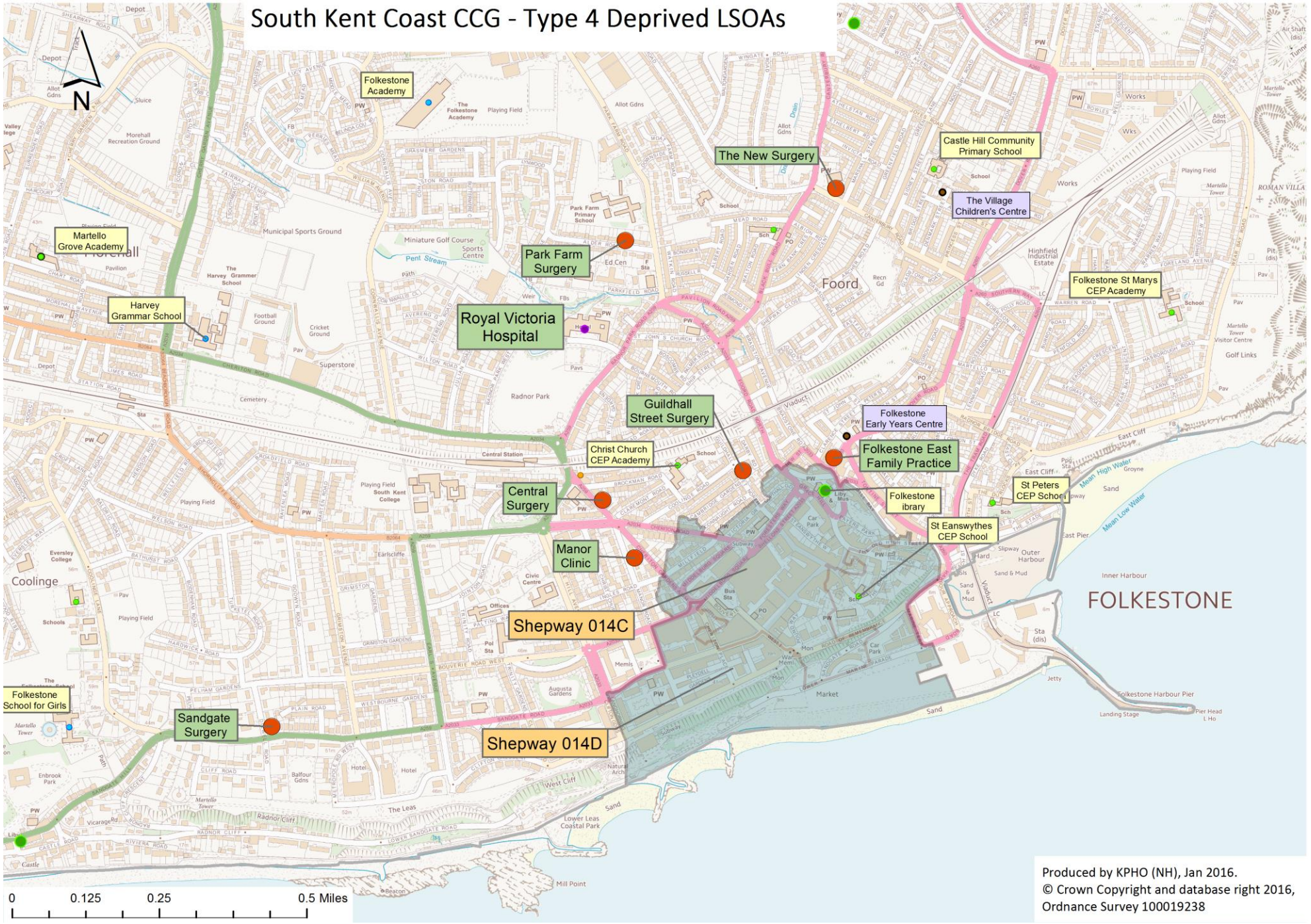
Improve living environment and good affordable housing

South Kent Coast CCG - Type 4 Deprived LSOAs



Produced by KPHO (NH), Jan 2016.

South Kent Coast CCG - Type 4 Deprived LSOAs



Produced by KPHO (NH), Jan 2016.

GP Practices

GP Practices Serving Deprived LSOAs: Recorded Disease Prevalence

For the GP practices that serve LSOAs in the most deprived decile, we have analysed the recorded disease prevalence from QOF data (Quality Outcomes Framework). Note that the data shows recorded disease prevalence, and does not account for undiagnosed disease in the community.

- High recorded prevalence of epilepsy and Chronic Kidney Disease in many of these practices.

GP Practice		Asthma	Atrial Fibrillation	Cancer	Coronary Heart Disease	Chronic Kidney Disease	COPD	Diabetes	Heart Failure	Hyper-tension	Stroke & TIA	Mental health	Dementia	Epilepsy	Depression	Learning Disabilities
G82002	St James' Surgery	5.9	1.5	2.0	2.9	4.9	2.1	6.8	0.4	14.1	1.5	0.7	0.5	1.1	10.4	0.5
G82015	Pencester Surgery	5.9	1.6	2.4	3.2	4.3	1.9	6.7	0.6	13.6	1.9	0.8	0.7	1.1	13.8	0.5
G82086	The New Surgery	6.4	1.7	2.0	3.0	5.5	2.9	6.7	0.4	12.5	1.3	1.0	0.6	1.2	8.1	0.4
G82091	Guildhall Street Surgery	4.9	1.5	2.4	2.9	3.8	1.9	7.4	0.4	12.9	1.8	1.5	0.6	1.0	7.8	0.4
G82117	High Street Surgery	5.4	2.3	2.3	3.6	5.3	1.9	7.2	0.5	15.4	2.1	0.6	1.0	1.2	8.6	0.4
G82128	Peter Street Surgery	5.7	2.1	2.2	3.5	7.1	2.3	7.3	0.7	13.7	2.2	0.9	1.0	1.4	5.0	0.7
G82187	Folkestone East Family Practice	6.4	2.3	2.5	3.9	6.1	3.2	7.6	0.5	16.1	1.6	1.0	0.8	1.1	8.6	0.7
G82211	Aylesham Medical Practice	4.7	1.8	2.8	3.3	7.3	4.4	7.7	0.9	15.0	1.9	0.7	0.7	0.9	6.0	0.5
G82232	Manor Clinic	5.2	1.4	1.8	2.7	4.8	1.6	6.0	0.3	12.5	1.5	1.2	0.5	0.9	5.5	1.1
G82662	Pencester Health	3.2	0.7	1.3	1.8	2.5	1.2	5.2	0.3	8.4	0.9	0.8	0.4	1.1	7.6	1.1
G82729	White Cliffs Medical Centre	5.9	2.1	3.0	3.2	7.6	2.6	6.5	0.6	18.2	1.7	0.9	0.9	0.9	5.1	0.4

Denotes value is in the upper quartile for GP practices in Kent

Denotes value is in the lower quartile for GP practices in Kent

Figures for chronic kidney disease (CKD), epilepsy and depression related to patients aged 18+, figures for diabetes to patients aged 17+. Other measures (including learning disability) related to all ages

Source: HSCIC - Quality and Outcomes Framework (QOF) for April 2014 - March 2015, prepared by KPHO (RK), December 2015

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Data Sources

1-6 Age-standardised mortality rates, 2006-2014. Source: PCMD. **2** ICD10: I00-I99. **3** ICD10: J00-J99. **4** ICD10: C00-C97. **5** ICD10: U00-Y99. **6** ICD10: F10, G31.2, G62.1, I42.6, K29.2, K70, K73, K74, K86.0, X45, X65, Y15.

7 Emergency admissions, 2012/13-2013/14. Source: SUS.

8 % self-reporting day-to-day activities 'limited a lot', 2011. Source: Census .

9 Modelled based on smoking prevalence data by Mosaic type. Source: Experian (TGI: 'Heavy', 'Medium' & 'Light' smokers combined).

10 Modelled based on % who do not exercise by Mosaic type. Source: Experian (TGI).

11-12 % children measured who were obese, 2013/14. Source: NCMP.

13 Modelled based on % who claim to eat '5-a-day' fruit and vegetables by Mosaic type. Source: Experian (TGI).

14 Modelled mental health prevalence based on GP practice-level data, 2014/15. Source: QOF.

15-16 Modelled wellbeing based on ONS Annual Population Survey (APS) data by Acorn type, 2011/12. Source: DCLG. **15** % scoring 0-6 for 'Overall, how satisfied are you with your life nowadays?' **16** % scoring 0-6 for 'Overall, to what extent do you feel the things you do in your life are worthwhile?'

17 Modelled based on median household income data by Mosaic type. Source: Experian (ConsumerView).

18 % claiming out of work benefits (defined as all those aged 16-64 who are jobseekers, claiming ESA & incapacity benefits, lone parents claiming Income Support and others on income related benefits), February 2015. Source: DWP (from Nomis).

19 % Year R pupils not achieving a good level of development, 2015. Source: KCC, MIU.

20 % pupils not achieving 5+ A*-C GCSEs (including English & Maths) at the end of Key Stage 4, 2015. Source: KCC, MIU.

21 % with no qualifications (based on persons aged 16+), 2011. Source: Census.

22 Education, Training & Skills IMD domain (average score), 2015. Source: DCLG.

23 % of households with no car or van, 2011. Source: Census.

24 % of households living in social rented accommodation, 2011. Source: Census.

25 % of households living in private rented accommodation, 2011. Source: Census.

26 % of households with an occupancy rating of -2 (i.e. with 2 too few rooms), 2011. Source: Census.

27 % of households with accommodation type 'shared dwellings', 2011. Source: Census.

28 % of households not living at the same address a year ago, 2011. Source: Census. Please note that OAs E00124937 & E00166800 have been removed from this analysis due to the undue influence of Eastchurch prison on levels of transience.

29 % of households with no adults or one adult and one or more children, 2011. Source: Census.

30-32 Distance to nearest GP/pharmacy/A&E or Urgent Care centre (in miles, as the crow flies from population weighted centroid of LSOA), 2015. Source: KCC Business Intelligence.

33 Crime rate (recorded crime per 1,000 population), Oct 2013 - Sept 2015. Source: data.police.uk.

34 Living Environment IMD domain (average score), 2015. Source: DCLG.

35 Index of Multiple Deprivation (IMD) (average score), 2015. Source: DCLG.