

Working Draft

Healthy Lives: Healthy Kent

**Kent's Health Inequality Action Plan  
2012 - 2015**  
*The Six Stages of the Life Course*



## INTRODUCTION

### ***Foreword – Graham Gibbens, Cabinet Member for Adult Social Care and Public Health (DRAFT TO BE AGREED)***

We live in an age where everyone's health is improving and we are all living longer. 100 years ago the average life span was 47 years. Now it is 80 years.

However there are still people in our communities who are not sharing in these benefits. If you are wealthier you are not only likely to live longer than someone who is poorer, but also to live for more years in better health or disease free.

There are many reasons for this. What happens to you during your life time has a huge impact on your health- including how much you earn, what you eat, whether you drink or smoke, what qualifications you have, what job you do and the place where you live.

The Government is returning responsibility for public health to local government because local government has power over many of those things that affect our health – especially housing, regeneration, planning, education, services for children and young people and vulnerable adults, leisure and green spaces, fire and road safety.

We want all residents in Kent to live longer, healthier lives regardless of where they live or their income. We

want to improve the lives of the poorest fastest to reduce the inequality that exists between the richest and poorest in our communities.

Tackling disadvantage is one of Kent's three ambitions and is key to our Community Strategy -theVision for Kent. At a time of austerity, when more people are facing economic hardship this Action Plan shows how the strong partnerships that exist across key public services in Kent will enable us to increase opportunities for people and communities to take control of their health and wellbeing.

### ***Foreword– Meradin Peachey, Director for Public Health-to be added***

The Kent County Council Health Inequalities Strategy (2008) sets out the direction and approach to reducing health inequalities in Kent.

The Public Health White Paper of 2011 states that by 2013, responsibility for many areas of Public Health will be transferred from Primary Care Trusts to the Local Authority. In Kent, an early shadow arrangement has already commenced, enabling a stronger partnership and collaborative commitment to reducing inequalities and greater opportunities for addressing the wider determinants of health and individual lifestyles that determine fundamental outcomes for people.

The Kent Health Inequalities Action Plan refreshes the commitment and strengthens the contributions made by all key stakeholders. It has a wider and more collective

ownership and commitment to health inequalities, so that we can all work together to really make a difference. This will require a focused, targeted approach to inequalities and strong partnerships with the Kent Community to gain insight into attitudes and behaviours raise aspirations.

Over £21bn of the UK's annual health budget has been spent on reducing health inequalities and yet the gap between the richest and poorest in society is not always reducing reduced. Under the new Local Authority responsibilities there is an opportunity to ensure that an appropriate proportion of health inequalities funding can now be committed to reducing the cause and not just tackling the consequences of inequalities.

This Action Plan, driven by the Joint Strategic Needs Assessment and Marmot's Life-course objectives provides a clear, focused commitment to how and by when we will see outcomes to reduce to the inequalities gap.

**Main causes of deaths** in England –Wales 2001 (ONS)  
The greatest (and broadest) measure of health inequalities is 'life expectancy at birth'. Against this measure, the UK is currently positioned 28<sup>th</sup> in the world with main causes of premature death:

1. Circulatory Disease 219,087
2. Cancers 136,234
3. All other causes 105,201
4. Respiratory 67,468

Access to early diagnosis and treatment pathways are essential to effectively treat people with these conditions,

but it is more efficient and beneficial to prevent the conditions in the first place. This requires targeting health promotion and interventions, in ways that best reach those more at risk of conditions, most of which are prevalent in areas of deprivation and low socio-economic groups. By developing the Mental Health and Wellbeing Impact Assessment, we will produce a screening tool that can demonstrate that the right people are accessing interventions. Together, Public, Private, Voluntary sectors can contribute to reducing the risk and prevalence of these health conditions that result in premature mortality disproportionately among the more deprived groups.

#### Developing the Action Plan

This Action Plan is centred around needs and priorities identified in Kent's Joint Strategic Needs Assessment and which in turn, informs the Strategies, Business Plans and Local Delivery Frameworks across the Local Authority. As the responsibility for Public Health transfers into Local Authorities by 2013 it is a timely opportunity for Public, Private, Voluntary sectors and social enterprises to work collaboratively and join forces to reach a variety of aspects of people's lives in order to make a difference. Together, we can be smarter in the effective targeting of inequalities; intelligence held by the Kent Public Health Observatory and Mosaic; re-modeling existing screening tools such as the Mental Wellbeing Impact Assessment and listening to the public voice should be routinely applied and mainstreamed throughout the Public Sector. These will be essential tasks to supporting the Action Plan.

The Health Inequalities Action Plan has been composed under the 6 Marmot Policy Objectives. Under each objective a set of priorities have been identified from the JSNA and partners have agreed actions that support them. Only actions that demonstrate the effective targeting of reducing inequalities for most vulnerable groups have been included. Health promotion issues that are widespread in all social and local groups and not endemic in health inequalities (such as dementia) have not been included. Each chapter also highlights the

significance to Districts who have a role in prioritising health inequalities in their locality. Lastly but importantly, all actions include measurable indicators to ensure that progress can be monitored against health inequalities. All stakeholders are committed to aspiring to achieve a measure of good practice under the 'What Good Will Look Like in 2015' section. This is where the scaling up and systematic delivery of effective programmes with robust outcomes will come into effect and where challenges, risks and innovation will need to be applied.



## **Delivering in Kent – Through Partnership Working**

The Marmot Review (Marmot 2010) identified 6 key policy areas where action is most likely to reduce health Inequalities:

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

These policy areas fall within the remit of local government which therefore has a significant role to play in supporting public health. Places where people live, work, play, the housing they live in, how well educated they are, opportunities for work and leisure all contribute to their health and wellbeing. It is clear that Central Government expects local government to collectively bring the power and influence of partnerships to bear on tackling these social determinants and that Local Authorities coming together in partnership are better placed to tackle upstream policies than the NHS. Alongside the Public sector organisations of Kent County Council, the District Councils, Police, Fire and Rescue Service and Health the 3rd Sector will play a vital role in supporting delivery of the Action Plan.

Kent has embraced this challenge through the Sustainable Community Strategy *Vision for Kent 2012-2022*. The Vision for Kent sets out three Countywide Ambitions that will guide the direction of public services in Kent for the next ten years:

- Ambition 1 - To grow the economy
- Ambition 2 - To tackle disadvantage
- Ambition 3 - To put citizens in control
- 

It puts emphasis on economic regeneration, work creation, supporting vulnerable people, a good standard of living and the development of healthy and sustainable places and communities. (also see appendix 2). This Action Plan is sponsored by Ambition Board 2 and is integral to work in Kent to tackle disadvantage.

In 2011 Kent County Council adopted the policy objectives from the Marmot Review as the foundation for its public health policy. This action plan stemming from Marmot is part of a framework for the delivery of its public health work.

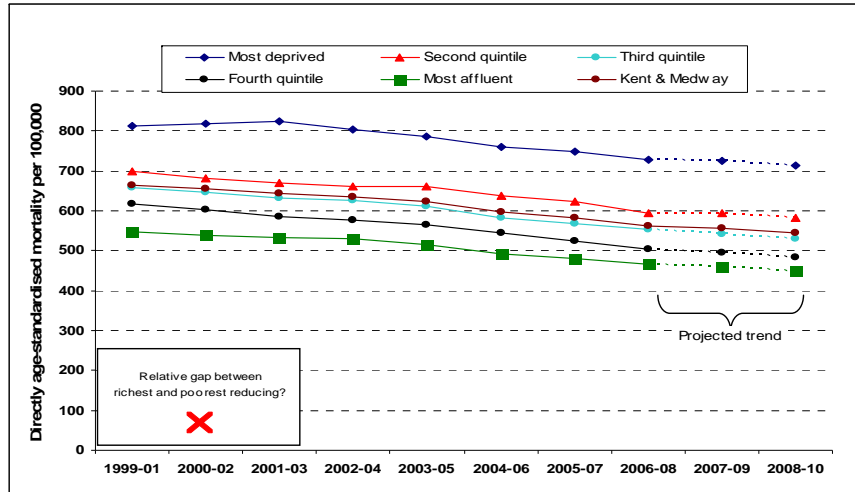
*'People's health and well-being will be at the heart of everything local councils do. It's nonsense to think that health can be tackled on its own. Directors of public health will be able to champion local co-operation so that health issues are considered alongside housing, transport, and education.'*

*Health Secretary Andrew Lansley,  
November 2010*

### **Why do we need an action plan?**

There is a wide range of public health programmes in Kent to support lifestyle change and health screening. These interventions are showing impact with health outcomes improving in Kent. However the gap in health inequalities in Kent is not narrowing despite continuing partnership effort and investment and there is little evidence to suggest which of the available interventions would be the most effective in delivering reductions in health inequalities.

In Kent there has been a focus through partnership working and the Local Area Agreements on improving outcomes for more than 10 years. However Sexton (2010) demonstrated that whilst there is some convergence in middle income groups health inequalities are not reducing between the richest and poorest in Kent.



**All age, all cause mortality rates, 3-year averages, Kent & Medway  
Sexton 2010**

Marmot states that success is more likely to come from the cumulative impact from a range of complementary programmes than from any one individual programme and through more effective, coherent delivery systems and accountability mechanisms.

In order for the health Inequalities action plan to be effective and influence the Health and Wellbeing Board to commission interventions that have proven to be effective for reducing health inequalities further work is required on impact assessment and evaluation.

This approach is timely in that we will expect to see increasing numbers facing hardship and economic deprivation caused by the recession. It will be difficult to show through data collection alone any narrowing of the gap in health inequalities when environmental circumstances will lead to growth in those experiencing poorer health outcomes despite continuing intervention and prioritisation by local authorities.

A series of strategic interventions or tools will be introduced as a new way of working. These tools will underpin Health Inequality policy and provision and will help assess impact on health inequalities at the point of commissioning a service rather than relying wholly on data collection at a future point in time. The Health Inequalities Action Plan provides the overarching framework within which new ways of working and adoption of strategic tools will be introduced.

## Delivering in Kent – supporting effective local delivery with a range of strategic tools

### a. Understanding the needs of our communities

- Social care maps through the Kent and Medway Public Health Observatory, along with local health profiles providing a much greater understanding of our local communities and their needs.
  - JSNA and Social Care maps- ([www.kmpho.nhs.uk/jsna/](http://www.kmpho.nhs.uk/jsna/))
  - District and Kent Health Profiles from the Department of health ([www.apho.org.uk/resource/view.aspx?QN=HP\\_RESULTS&GEOGRAPHY=29](http://www.apho.org.uk/resource/view.aspx?QN=HP_RESULTS&GEOGRAPHY=29))
  - Engaging with communities and listening to their views

As the Health and Wellbeing Board is now operating in shadow form in Kent it is an opportunity to use the joint strategic needs assessment to highlight population needs and gaps in service delivery. Priorities can then be agreed that will focus on where gaps exist. The Health Inequalities Action Plan has drawn heavily on these sources to identify priorities alongside consultation with staff in Public Health, Kent Community Health Trust and Districts and other KCC Directorates.

### b. Supporting Strategic Commissioning

The development of a tool to evidence the effectiveness of any proposed intervention will enable commissioners to make smart decisions about how Kent targets its resources and can close the inequality gap, over the short term rather than using longitudinal data lag as a reason why efficacy cannot be proven. The Health Inequalities National Support Team (HINST) has developed a tool to help model the potential contribution of interventions necessary to achieve targets. (HINST 2010)

***The HINST Diagnostic tool (see appendix 3) will support the Board to achieve its policy objectives and develop a challenge to providers that will underpin future commissioning.***

The focus of response strategies, both county and locality, should be targeted in accordance with the principles of equity (greater attention and investment to areas and issues of greatest need) in order to maximise and improve overall outcomes.)

### c. How will we know what works? Operational Framework

i) **Impact assessment Tool**

Alongside adoption of the HINST Diagnostic tool at a strategic level a further intervention is needed to assess proposals for local programmes. The development of a health inequalities impact assessment tool will enable commissioners to improve and evidence impact in a field that is recognised as being difficult to assess.

Long-term outcomes of interventions, including those for health, are complex to evaluate and measure. Isolating the impact of a particular mechanism or approach over time is particularly challenging. (Marmot 2010)

Quantifying and modelling the impact of interventions is integral to cost effective commissioning and delivering targets and positive outcomes for the population.

This approach will also provide the Board with evidence of improvements to facilitate access to the health premiums that the Government is proposing to reward progress on specific public health outcomes.

The mental wellbeing impact assessment developed by the National MWIA Collaborative (England) and published in May 2011 will put wellbeing at the centre of our planning at a time when policy places an increasing emphasis on that aspect of our health as a key part of addressing inequalities.

“There is growing evidence that mental well-being is a key pathway through which inequalities impact on health. The importance of mental health and well-being is directly and indirectly related at every level to human responses to inequalities” (Friedli 2009)

The Association of Public Health Observatories recognises the MWIA and how it focuses on population groups who may experience health inequalities and social injustice with a particular emphasis on those most at risk of poorer mental well-being. The MWIA also makes the link with physical health and wider social determinants and goes further in developing indicators to measure the actual impacts over time.

ii) **Invest to Save**

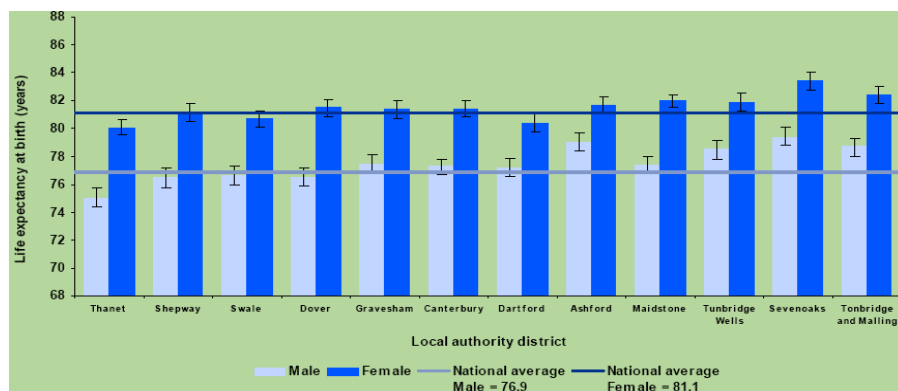
Abelson et al (2003) posited that for every \$1 spent on tobacco cessation programmes in Australia a saving was made of \$2. Mapping this kind of evidence will support the case for investing in public health interventions by demonstrating the potential returns on that investment for the public sector.

Commissioners should be aware of a range of tools available to help them assess cost benefits. The National Institute for Health and Clinical Excellence (NICE) proposed a three step approach to determine the benefits of public health interventions (2010) and recommended the need for benefits to be reported in 'natural units', such as life years saved and reductions in hospital admissions as well as through financial modeling.



#### d. Making it Work: Local Delivery Framework (see appendix 1)

Kent has the biggest County Council in England and there are wide variations in health inequalities between Districts. This can be demonstrated through the correlation between areas of deprivation and a reduced life expectancy as shown in the graph below. Thanet is the most deprived area in Kent and has the shortest life expectancy. Sevenoaks is the least deprived and has the longest life expectancy.



**Life Expectancy at Birth for Kent Residents (source LHO 2007)**

Whilst this action plan provides a framework for delivery it does not aim to be prescriptive and indeed the vision is that Local Boards will use the template and tools identified here as a framework from which they can develop a local action plan that will address the challenges and priorities in their own communities.

- **Locality Boards are in development across the County. Relationships between the HWB and the Locality Boards will be developed as the locality board model is developed. Links to Locality Boards remains important, reflecting the complexities of health and social care needs across Kent.**

- Local Health and Wellbeing groups will be developed to support the work of locality boards and the Health and Wellbeing Board.

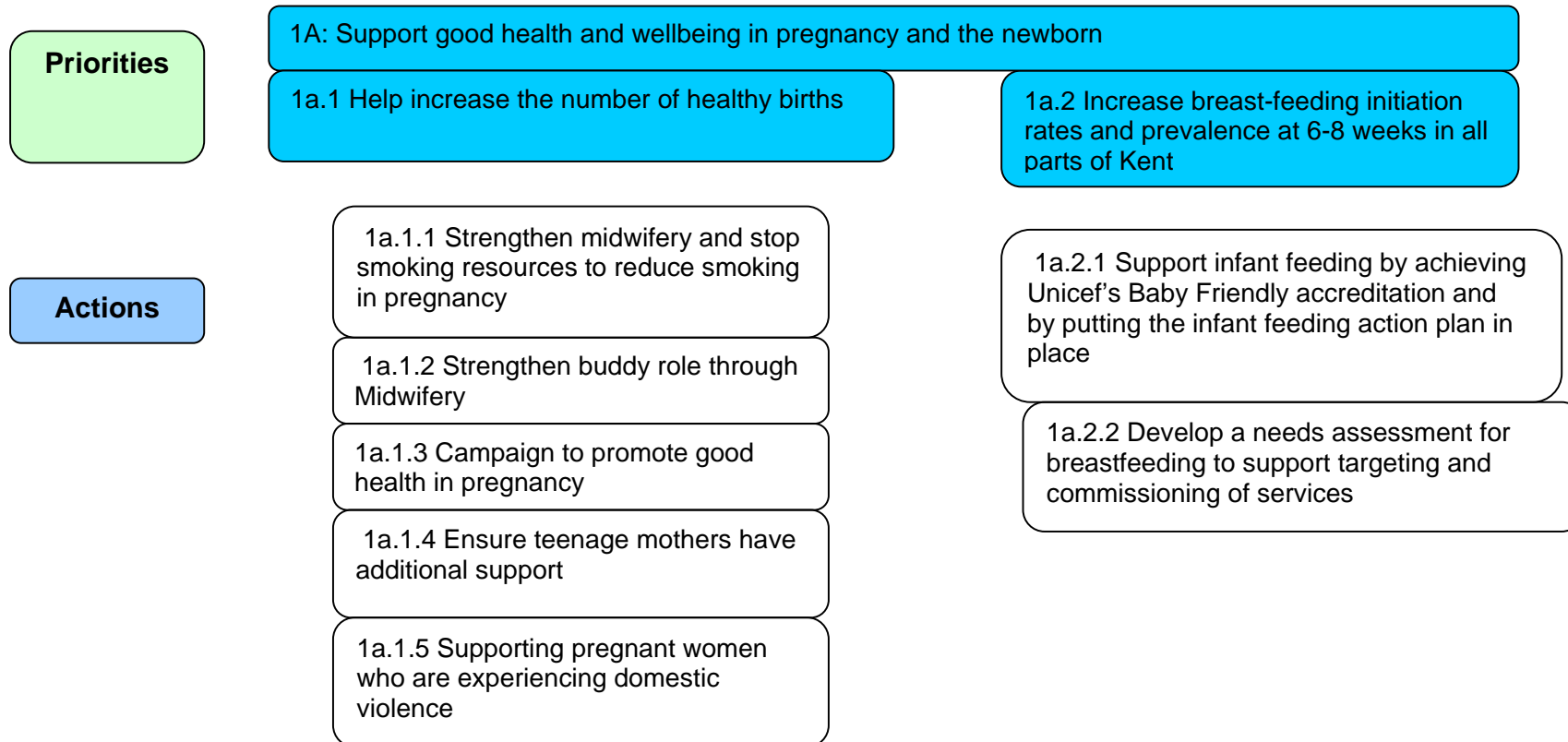
Marmot argues that to narrow the gap actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. A local approach will support Kent to reduce the steepness of the social gradient in health.

# 1: Give every child the best start in life

Improving health in the early years of life contributes considerably to better health outcomes in later life, with reduced levels of diabetes, coronary heart disease and hypertension, all of which have a significant impact on the NHS as well as wider society, children and their families.

*The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. (Marmot Review 2010)*

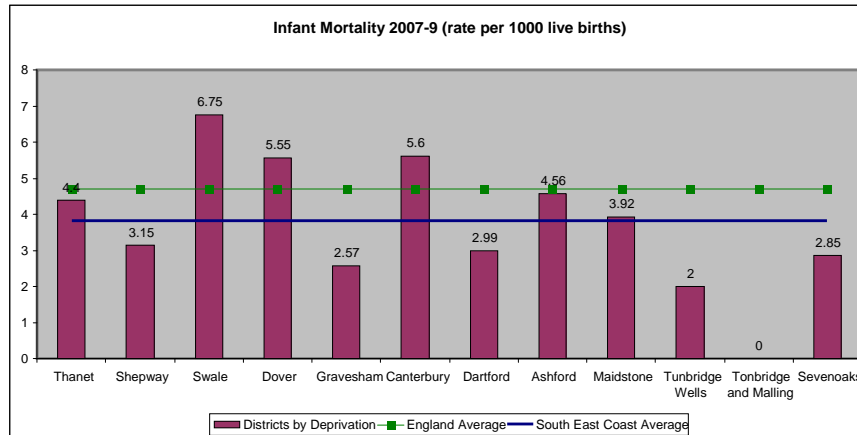
## Objective 1A: Give every child the best start in life (Conception-9 months)



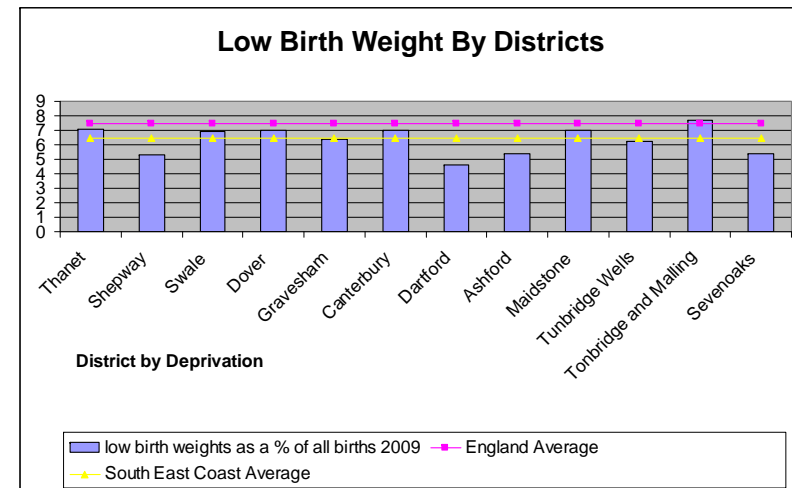
## 1A. Give every child the best start in life

### Priority 1a.1 Help increase number of healthy births

- The overall rate for infant mortality for Kent has been consistently lower than the England and Wales rate. However there are differences in infant mortality rates which could point to a health inequality based on socio-economic circumstances. There are a higher number of infant deaths in East Kent and latest data indicates that Swale far exceeds the England average with Canterbury and Dover above the England average. There were NO infant deaths reported in Tonbridge and Malling. It should be noted that the incidence is low and the overall trend can be distorted by specific cases.



Chimat 2011



- Low birth weight has serious consequences for health in later life. Increased viability and survival of very pre-term infants due to advances in medical technology will account for some of the very low birth rate weights.
- Smoking in pregnancy is known to affect both birth weight and incidence of infant mortality and continues to impact on the health of a child.
- Domestic violence is more likely to occur to women in their reproductive years, from lower socio-economic areas and often increases during pregnancy.
- A particularly vulnerable group is teenage mothers who are much more likely to be smoking both at booking and at delivery posing considerable risk to both themselves and their babies. They are also highly likely to access services late, potentially

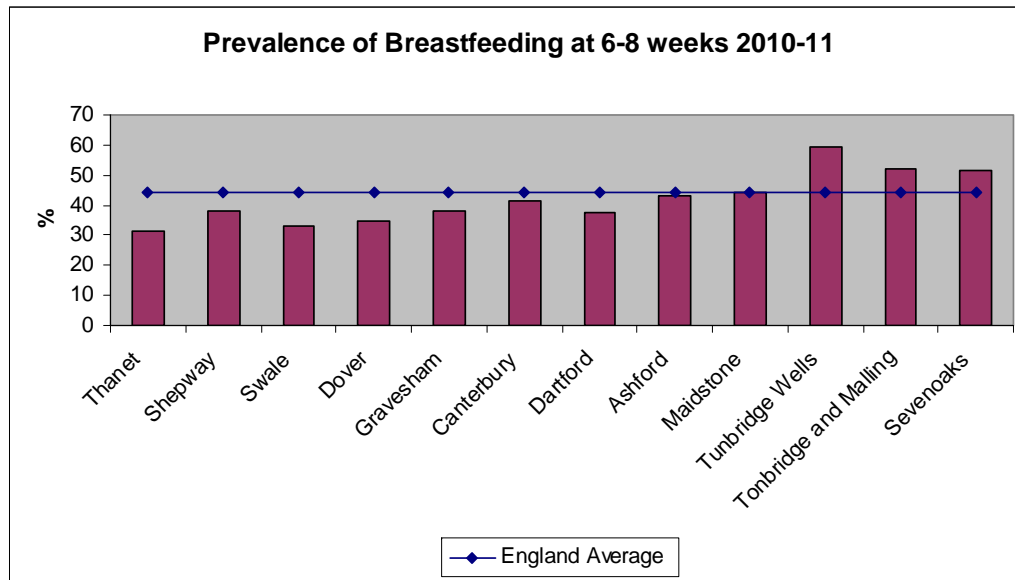
further compromising their care. Teenage mothers had a statistically significant higher rate of stillbirths. Postnatally they had much lower rates of breastfeeding at both birth at 6-8 weeks.

**1a.2 Support infant feeding by achieving Unicef’s Baby Friendly accreditation**

Breastfeeding makes an important contribution to the health of mothers and infants. The Government has committed to increase support for breastfeeding as part of its strategy to reduce health inequalities and has set a target to increase breastfeeding initiation rates by 2% per year, focusing particularly on women from disadvantaged groups. In Kent averages in breastfeeding at birth mask significant disparity between Hospital Trusts. For example from April- June 2011 65% of new mothers breastfed at the Darent Valley Hospital, 78% did so at Maidstone and Tunbridge Wells.

Initiation Rates	Eastern and Coastal Kent	West Kent PCT	Kent 2010-2011	England Average
Breastfeeding at birth %	69.22	71.46	73.4	74.6

CHIMAT breastfeeding profile East & West Kent 2011 child profile- chimat



The rate of exclusive breastfeeding at birth and at 6-8 weeks confirms that women in the most deprived areas are less likely to breastfeed. The biggest drop off in breast feeding occurs by the fourth day after birth.

**Local Profile**

District comparison to the England average showing where priorities have been identified for local areas.

	Breast Feeding Initiation	Low Birth weight (To SHA average)	Infant Mortality	Smoking in pregnancy
Ashford	x			x
Canterbury	x	x		x
Dartford		x		
Dover	x			x
Gravesham				-
Maidstone		x		-
Sevenoaks				-
Shepway	x			x
Swale	x	x	x	x
Thanet	x	x		x
Tonbridge & Malling		x		
Tunbridge Wells				
Kent	x			x

Source: Department of Health. © Crown Copyright 2011'.

## The Aspirations

Planners and Commissioners should

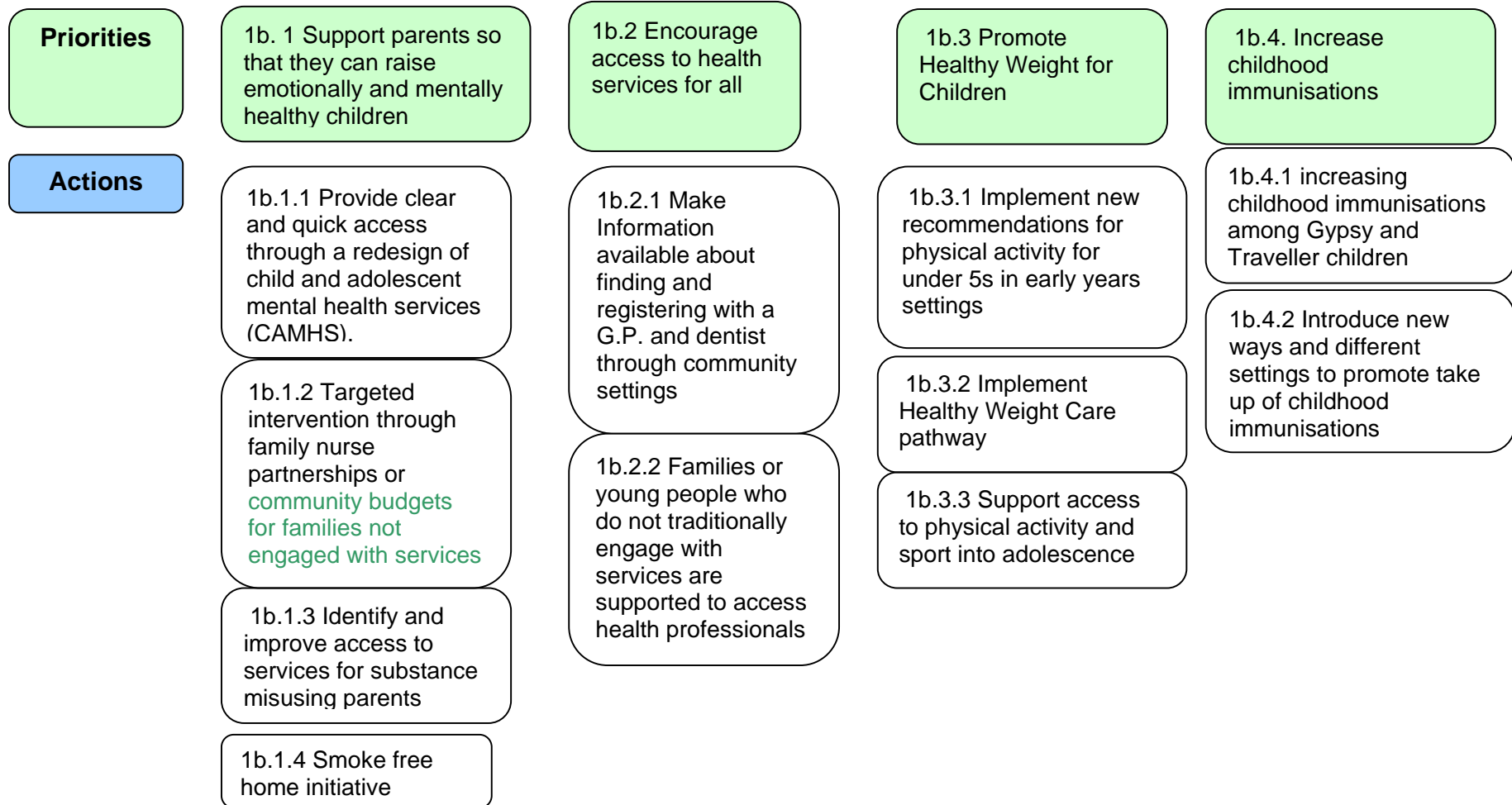
- i) use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.
- ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively
- iii) Assess impact on health inequalities by applying the Impact assessment tool

Action	What good will look like in 2015	Aspirational Targets
<b>1a.1 Increase Numbers of Healthy Births</b>		
All women are supported throughout their pregnancy, know how and when to access services and can easily find support in their community. They have access to help and information about avoidable risks and lifestyle choices to keep their baby healthy. Women in deprived areas or in at risk groups receive additional targeted support in ways that suit them and they access services in good time.		<ul style="list-style-type: none"> <li>• Reduction in Infant mortality</li> <li>• 1% reduction in smoking in pregnancy per annum</li> <li>• 1% reduction in low birth weight</li> </ul>
1a.1.1 Strengthen midwifery and stop smoking	Linking pathways between acute and primary interventions and provide motivational interview training skills for Midwives	

resources to reduce smoking in pregnancy		
1a.1.2 Strengthen midwifery resources to provide health buddy support through pregnancy	<p>Giving priority to pre and post natal interventions including intensive home visiting with outreach to increase take-up from the most disadvantaged families</p> <p>Health buddy support -repeated broad based contacts with either a professional or peer educator both before and after birth to assist in take up of breast feeding and smoking cessation</p>	
1a.1.3 Deliver effective campaign to promote good health and wellbeing in pregnancy	All women have access to good information and signposting to support lifestyle choices and wellbeing	
1a.1.4 Ensure teenage mothers have additional support	<p>New ways of working: Children's Centres taking on the main role for providing tailored support to teenage parents including the facilitation of provision of specific education programmes within the young parent support groups.</p> <p>Reduction in greater prevalence of smoking among teenage mums in areas of deprivation. Smoking cessation support is available in new non medical places targeted to where mums will go- soft play centres, libraries, children centres.</p>	<p>For teenage mums-</p> <ul style="list-style-type: none"> <li>• 1% reduction in low birth weight</li> <li>• 2% Increase breast feeding initiation rates</li> <li>• 2% Increase in breast feeding prevalence 6-8 weeks after birth</li> <li>• Reduce greater prevalence of smoking amongst teenage Mums in areas of deprivation</li> </ul>
1a.1.5 Support pregnant women who are experiencing domestic violence	<p>Front line staff are given training and awareness raising about domestic violence, how to recognize it and what support is available</p> <p>NICE Guidelines for women with complex social circumstances implemented</p>	
<b>1a.2 Increase breast-feeding initiation rates and prevalence at 6-8 weeks in all parts of Kent</b>		
<p>The Baby Friendly Initiative works with the health-care system to ensure a high standard of care for pregnant women and breastfeeding mothers and babies.</p> <p>In whatever way a woman chooses to feed her baby health care professionals will make sure mums are supported and confident</p> <p>The Kent and Medway Infant feeding plan will be fully implemented.</p>		<ul style="list-style-type: none"> <li>• 2% Increase breast feeding initiation rates</li> <li>• 2% Increase in breast feeding prevalence 6-8 weeks after birth particularly in the most disadvantaged groups</li> <li>• Healthy Start Scheme</li> </ul>
1a.2.1 Support infant	Working through maternity units, hospitals, children centres,	

<p>feeding by achieving Unicef's Baby Friendly accreditation and and by putting the infant feeding action plan in place</p>	<p>midwives and Health Visitors to achieve Unicef's baby friendly accreditation. Best practice is in place in a range of medical and community settings and Unicef's assessment and accreditation process is in progress recognising those that have achieved the required standard</p> <p>There will be a quarter on quarter increase in the uptake of the Healthy Start scheme-a statutory scheme providing a nutritional safety net and encouragement for breastfeeding and healthy eating for pregnant women and children under 4 in low income and disadvantaged families across the UK.</p>	
<p>1a.2.2 Develop a needs assessment for breastfeeding to support targeting and commissioning of services</p>	<p>The needs assessment is being used to identify groups or areas where targeted support will increase breastfeeding</p>	<p>2% increase in breastfeeding rates in the most disadvantaged groups</p>

## Objective 1B: Give every child the best start in life (9 months+)



## Objective 1B: Give every child the best start in life (9 months+)

### Priority 1b. 1 Support parents so that they can raise emotionally and mentally healthy children

The role parents play in the health and wellbeing of their children cannot be overstated. Assisting parents to make the right choices to support healthy outcomes is a key part of tackling health inequalities for young people. The county council and districts are uniquely placed to communicate with and support parents through children centres, schools, council services, libraries and Gateways. The Children's JSNA recommends that

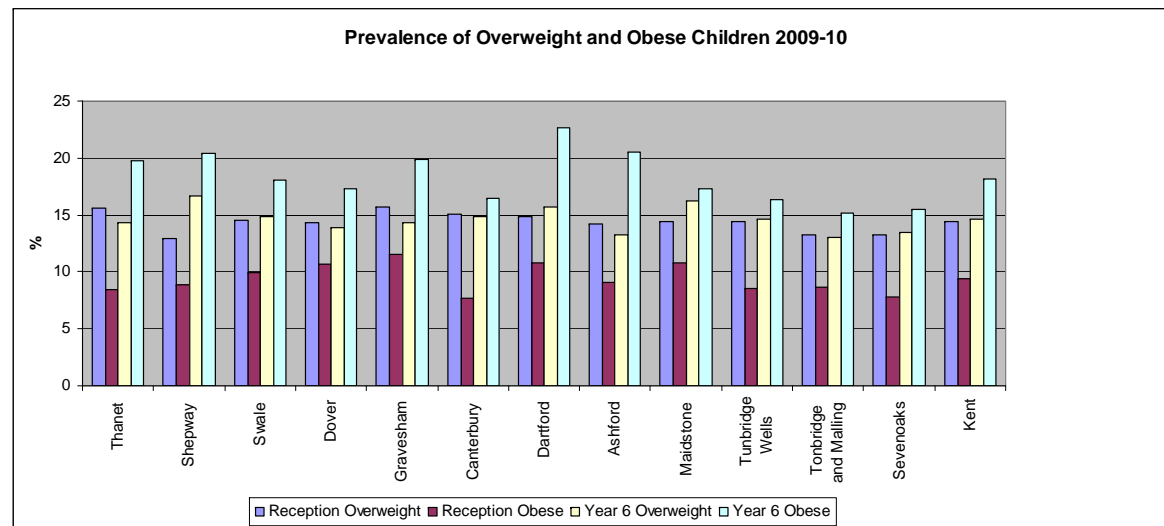
- All agencies should target their approach to focusing on the **family** as a whole rather than children's behaviour.
- Commissioning of services should recognise **home visiting** as a key intervention to addressing inter-generational improvements in parenting, child behaviour and cognitive development.

### Priority 1b.2 Encourage access to health services for all

GP and Dentist registrations- access to health professionals is vital to support good health outcomes and finding and visiting a GP can be more difficult for those experiencing disruption in their lives- including looked after children and the homeless.

### Priority 1b.3 Promote Healthy Weight for Children

Mounting evidence suggests that a critical period during which to prevent childhood obesity and its related consequences is before the age of five. The best thing we can do for children from 0-5 is create ways of life which continue to make obesity unlikely. Children who live in more deprived areas are more likely to be overweight and obese than those from the most affluent areas. Making what may seem like simple changes to daily habits (physical and nutritional) is sometimes simply too difficult given all the other difficulties many families have to confront.



### Priority 1b.4 Increase childhood immunisations

The national immunisation programme is an essential part of protecting children's health. Low vaccine uptake puts children at risk. Measles has made resurgence in the UK and the rate of take up of the MMR vaccine in Kent whilst improving, is not at the 95% level recorded by the World Health Organisation as being necessary to prevent an outbreak.

#### Percentage of children immunised by their 5<sup>th</sup> birthday 2010-11

	DTP	Hib	DTPP	MMR	
	Primary %	Primary %	Booster %	First dose %	First and second dose %
West Kent PCT	93.7	94.9	91.4	92.3	87.4
Eastern & Coastal Kent PCT	96.3	96.7	90.1	93.5	87.0
South East Coast	92.5	92.6	84.4	89.0	80.9
England	94.7	94.2	85.9	91.9	84.2

Diphtheria Tetanus, Polio (DTP) Diphtheria Tetanus, Polio, Pertussis (DTPP) Information Centre 2011

### Local Profile

	Tooth Decay (at age 12) All above average	Physically active children	Obese children yr 6
Ashford			
Canterbury			
Dartford			
Dover			
Gravesham			
Maidstone			
Sevenoaks			
Shepway			
Swale			
Thanet			
Tonbridge & Malling			
Tunbridge Wells			
Kent			

District comparison to the England average showing where priorities have been identified for local areas.

Source: Department of Health. © Crown Copyright 2011'.

## The Aspirations

Planners and Commissioners should

- i) use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.
- ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively
- iii) Assess impact on health inequalities by applying the Impact assessment tool

Action	What good will look like in 2015	Targets and achievements
<b>1b. 1 Support parents so that they can raise emotionally and mentally healthy children</b>		
All our children have a right to a good childhood and a positive future. Parents and carers will feel supported to bring up their children to be physically, mentally and emotionally healthy, to help them fulfill their potential and equip them to contribute to society. Services will offer targeted support to those families that are finding it hard to cope or face challenging situations.		
1b.1.1 Provide clear and quick access through a redesign of child and adolescent mental health services (CAMHS)	CAMHS are easily accessible with short waiting times and improved access to psychological therapies  Routine support to meet social need via outreach to families is available through schools, parenting programmes, children's centres and key workers	Access to and effective treatment from Camhs outcomes indicator
1b.1.2 Target family support to the most vulnerable families	Family nurse prevention and the community budgets model are used to engage families in deprived areas or those facing additional challenges There is access to effective parenting programmes. Children are ready for school and families are supported through the transition to school	Crude rate of hospital admissions caused by unintentional and deliberate injuries in age 0-17 per 100,00 resident population Childhood development at 2-2.5 years
1b.1.3 Identify and improve access to services for substance misusing parents		
1b.1.4 Smoke free home initiative	Reduce amount of second hand smoke children are exposed to by making smoking outside the house the acceptable social norm	
<b>1b.2 Encouraging access to health services for all</b>		

1b.2.1 Information is available about finding a G.P. and dentist through community settings	Health Trainers making Information about finding a G.P. and dentist and how to register available at Gateways, Children's centres, schools and libraries. Health Trainers engaging with Gypsy and Travellers to increase numbers registered with GP & Dentist	<ul style="list-style-type: none"> <li>• All LAC having an annual health check</li> <li>• Rate of tooth decay in children aged 5 years</li> <li>• Increasing immunisation to 95% rate</li> </ul>
1b.2.2 Families or young people who do not traditionally engage with services are supported to access health professionals	Children and Young People from the following groups are able to get access to health services: <ul style="list-style-type: none"> <li>• People with a learning disability</li> <li>• Looked after children</li> <li>• Homeless or in temporary accommodation</li> <li>• Gypsies and travellers</li> </ul>	
<b>1b.3 Promote Healthy Weight for Children</b>		
Measures for early intervention are targeted to areas of deprivation. Parents and carers are supported and informed in the early years about adopting good habits - how breast feeding and the introduction of good eating habits, physical activity and sleeping routines are likely to prevent the development of obesity. Children and young people have access to physical activity, sport at school, healthy food at school, affordable leisure activities and places to play		<ul style="list-style-type: none"> <li>• From the 11/12 trend baseline we will aim to reduce the percentage increase from yr R to yr 6 by 1% per annum</li> </ul>
1b.3.1 Implement new recommendations for physical activity for under 5s in early years settings	Healthy Schools Team working in new ways with early years settings and rolling out the effective early years pilot to areas of deprivation Early years (under 5s) should be physically active daily for at least 180 minutes (three hours), spread throughout the day (once a child is able to walk.)	
1b.3.2 Implement Healthy Weight Care pathway	Improved referral rates to programmes from health care professionals to family healthy weight programmes such as MEND	
1b.3.3 Provide access to physical activity and sport into adolescence for all	Continue to develop opportunities and programmes with partners and the 3 <sup>rd</sup> Sector for young people to take part in sport – such as Sportivate and use the legacy of the 2012 Olympics and Para Olympics to promote the benefits of sport i.e. through the Kent school games  Revise and promote the Active Kent website to provide	<a href="http://www.kentsport.org/">http://www.kentsport.org/</a> <a href="http://www.activekent.co.uk/">http://www.activekent.co.uk/</a>

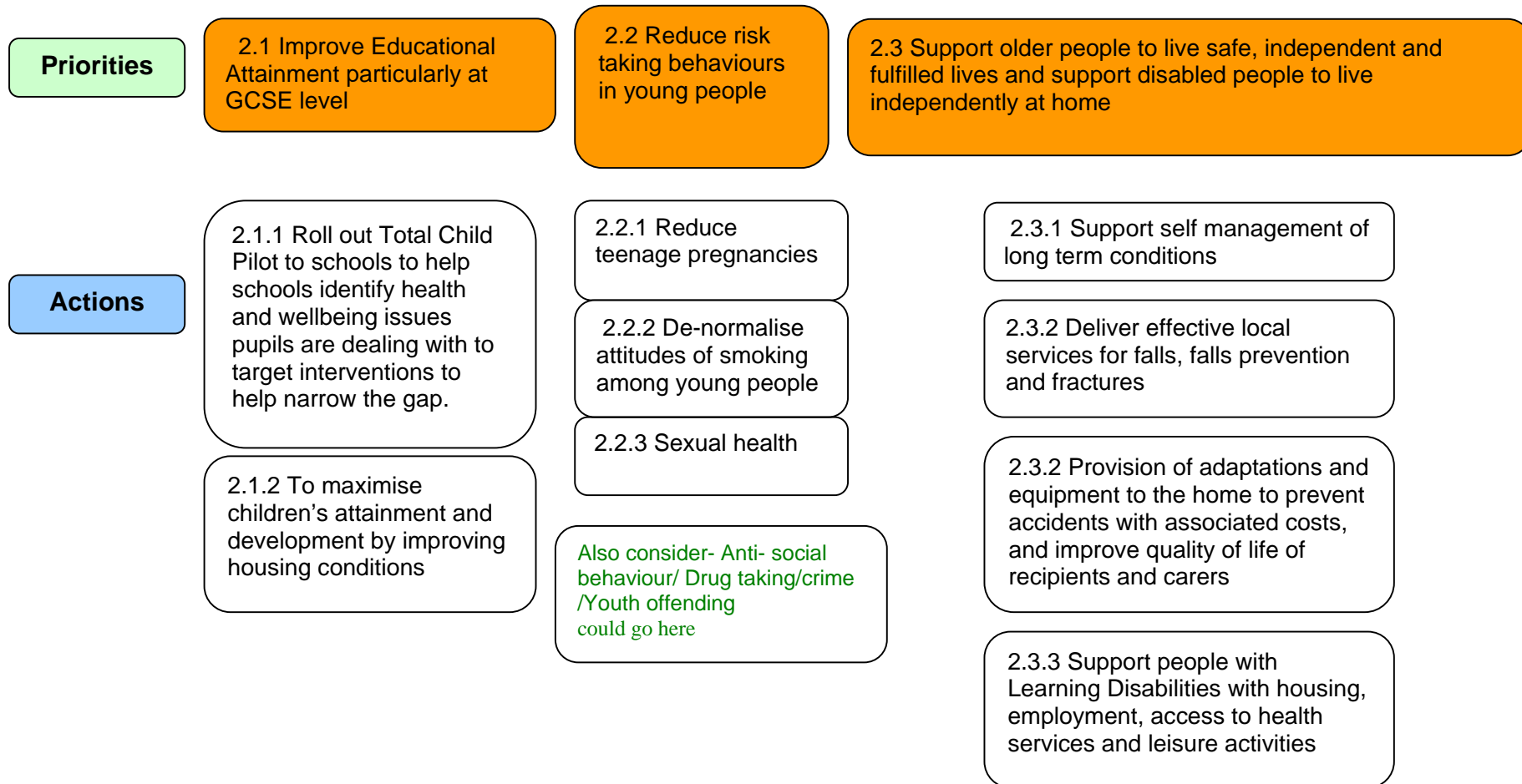
	information on local activities & services	
<b>1b.4 Increase childhood immunisations among most vulnerable groups</b>		
New, non medical places will be promoting and offering immunisations with specialist targeting to groups with low take up rates		<ul style="list-style-type: none"> <li>• 1% Increase in immunisations take up by age 5 in groups with low take up rates</li> </ul>
1b.4.1 Increasing childhood immunisations among Gypsy and Traveller children		
1b.4.2 Introduce new ways and different settings to promote take up of childhood immunisations	<ul style="list-style-type: none"> <li>• Promoting take-up in children's centres</li> <li>• Start in school programme as part of primary school registration in most deprived areas</li> <li>• Targeted Opportunistic Vaccinations for children presenting at A&amp; E</li> </ul>	

**2. Enable All Children, Young People And Adults To Maximise Their Capabilities And Have Control Over Their Lives**

*Central to our vision is the full development of people's capabilities across the social gradient.*

*Without life skills and readiness for work, as well as educational achievement, young people will not be able to fulfil their full potential, to flourish and take control over their lives  
(Marmot review 2010)*

Objective 2: Enable all children, Young People and adults to maximise their capabilities & have control over their lives

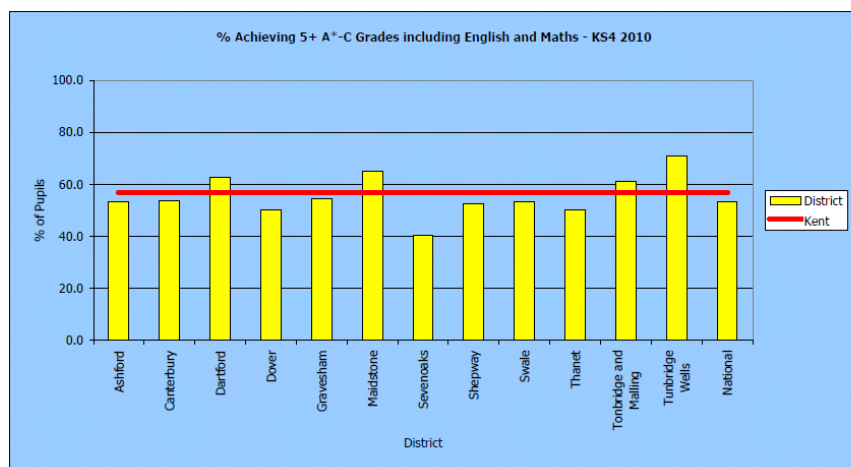


## Objective 2: Enable all children, Young People and adults to maximise their capabilities & have control over their lives

### Priority 2.1 Improve Educational Attainment particularly at GCSE level

There is a clear relationship between low educational attainment and poor health over a lifecycle. For young people educational attainment supports economic wellbeing- the ability to get and keep a job which indicates better mental wellbeing and health outcomes for the rest of their lives.

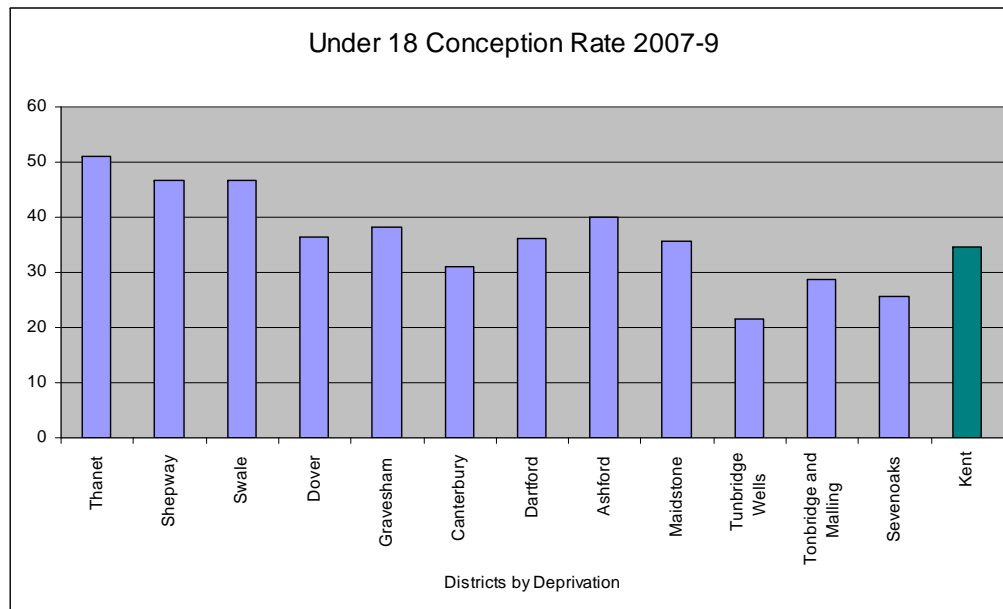
In 2009-10 GCSE statistics showed that around a third of pupils who had been on Free School Meals in the previous six years achieved five or more A\*- C grades, compared to more than two thirds of their fellow pupils. In Kent, children who take free school meals experience marked inequality in comparison to the achievement of their peers- including significantly lower outcomes at GCSE. Those children achieving 5+ A\*-C GCSEs are more likely to experience longer term employment and have the capability to retrain at least twice during a working life.



Whilst schools serving areas with significant concentrations of relative deprivation mainly do well against the England average they struggle to match the outcomes of the most affluent areas.

### 2.2 Reduce risk taking behaviours in young people

Teenage mothers and their children face particular inequalities: The link with a lack of aspiration is significant, young people need the motivation as well as the means to prevent pregnancy and engagement in education through the teenage years is a strong protective factor



In Kent the teenage pregnancy rate is 34.7 per 1000 females 15-17 years (2009) which compares favorably to an England rate of 38.

There is however significant difference in progress to reduce rates across the districts of Kent, with Canterbury having achieved the best reduction of 19% while Maidstone has demonstrated an increase of 10%.

(To avoid annual fluctuations rates are calculated on three year rolling averages.)

**Sexual health:** Sexually transmitted infections particularly affect young people and 15 to 24 year olds, particularly young women, continue to be the group most affected by sexually transmitted infections (STIs) in the UK or the group that most present for treatment. Untreated infection can lead to serious health problems, including infertility. Acute STIs diagnosed between 1998 and 2009, increased by 100% in the east Kent and west Kent clinics. Late diagnosis of HIV is a problem in some areas of Kent, for example almost 55% of HIV diagnoses in West Kent are classified as late diagnosis.

**Priority 2.3 Support older and disabled people to live independently**

**Long Term Conditions**

Services that promote the health, well being and independence of older people and, in so doing, prevent or delay the need for more intensive or institutional care, make a significant contribution to ameliorating health inequalities. (Marmot Review 2010)

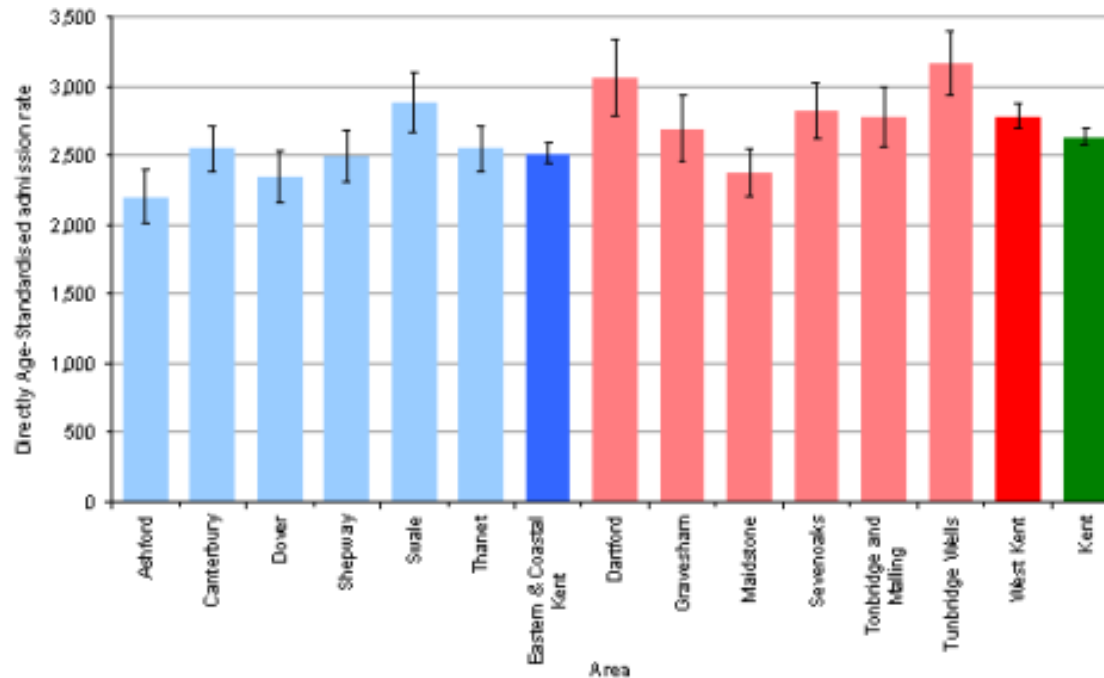
For adults and older people having choice and control over their own situation not only reduces pressure on health and social care services it also supports people to live more fulfilled and independent lives and reduces carer burden. Carers are more likely to suffer from a Long Term Conditions (LTC) themselves having cared for someone who has one or more LTCs.

Assistive technologies enable people with health and care needs, such as the frail elderly and those with Long Term Conditions to remain independent and empowered to self care in their own homes. The Kent Telehealth Pilot reported that people who use telehealth had fewer hospital admissions and shorter stays when they do, reduced GP contacts and in some cases fewer visits from

community nursing teams. Patients and carers also reported that their quality of life improved and that had a positive impact on them and their family and carers. If the principles of the pilot were to be applied to the LTC population (2006/7) across Kent the projected saving would be circa £7.5m to the health and social care economy.

## Falls

Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK, with large implications for the quality of life of older people who survive a fall. There are also considerable inequalities, both in terms of risk and longer term implications. Hip fracture is the most common injury related to falls in older people. More than 95% of hip fractures in adults ages 65 and older are caused by a fall. Hip fractures in the elderly and frail can lead to loss of mobility and loss of independence. For many older people it is the event that forces them to leave their homes and move into residential care. Mortality after hip fracture is high: around 30% for one year. Tunbridge Wells, Dartford and Swale have the highest falls related admissions by District.



Telecare supports people to live independently at home. By responding to falls alerted through the telecare service it is possible to prevent people from suffering from both a bad fall and then associated ongoing impacts that would inevitably arise if the individual was not found for a period of time. Current work with the ambulance service is being undertaken as the pattern of call outs show that typically an individual falls twice and that may result in transportation for a whole variety of reasons. The 3<sup>rd</sup> call nearly always results in a serious injury and then hospitalisation. Using historic call data and social care information it is possible to identify those most likely to be at risk of falling from the first call and install telecare on a short term or longer basis depending on the ongoing needs of that individual.

Training of paramedics and ambulance crews in the principles of telehealth and telecare will support decision making and 24 hr access to telecare and telehealth will reduce transportation rates and subsequent hospitalisation and length of stay

### **Support for People with a Learning Disability**

People with learning disabilities have poorer health than their non-disabled peers. These differences are to an extent avoidable, and as such represent health inequalities. The impact of these inequalities is serious. The research indicates that people with moderate to severe learning disabilities are three times as likely to die early than the general population.

*Improving Health and Lives – implications for social care commissioning and practice  
A discussion paper Sue Turner September 2011*

People with learning disabilities have a wide range of social and health care needs. This reflects the spectrum of severity for learning disabilities and the different conditions that may co-exist. People with learning disabilities also have needs generated by social exclusion, such as poverty, lack of housing and unemployment. Those with mild learning disabilities may need specialist support in mainstream education while they are children. Subsequently, they may need the same support/benefits as others in socially excluded groups, rather than specialist services. At higher levels of disability, however, many individuals will have lifelong needs for health and social care.

The Joint Strategic Needs Assessment identifies that people with a learning disability in Kent are more likely to be obese, have dementia, mental health problems, physical disability, sight and hearing impairments than the general population. They are less likely to access general health services resulting in low rates of health screening take up and poorer dental health. They often have communication difficulties or impairment of social ability. In 2007 46,700 people in Kent were believed to have a learning disability, 42,000 persons with a moderate learning disability and approximately 4,700 with a severe learning disability. Only a small proportion of these are in contact with Social Care Services. Having a learning disability can lead to restriction in participation in society- not only for the person with a disability but also their families and carers.

## Local Profile

District comparison to the England average showing where priorities have been identified for local areas.

	Teenage pregnancy U18	Hospital stays for self harm	Hip fractures in Over 65s All above average	GCSE achieved (5A*-c inc Eng & Maths)
Ashford				
Canterbury				
Dartford				
Dover				
Gravesham				
Maidstone				
Sevenoaks				May mask local issues
Shepway				
Swale				
Thanet				
Tonbridge & Malling				
Tunbridge Wells				

Source: Department of Health. © Crown Copyright 2011'.

## The Aspirations

Planners and Commissioners should

- i) use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.
- ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively
- iii) Assess impact on health inequalities by applying the Impact assessment tool

Action	What Good Will Look like in 2015	Targets and achievements
<b>2.1 Improve Educational Attainment particularly at GCSE level</b>		
2.1.1 Roll out Total Child Pilot to schools to help schools identify health and wellbeing issues pupils are dealing with to target interventions to help narrow the gap.	<ul style="list-style-type: none"> <li>Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education</li> <li>Consistently implementing the full range of extended services in and around schools</li> <li>Developing the school-based workforce to build their skills in working across school- home boundaries and addressing social and emotional development, physical and mental health and well-being.</li> </ul>	<ul style="list-style-type: none"> <li>Narrowing the gap between pupils on free school meals and their peers achieving 5* A-C</li> <li>Narrowing the gap between achievement across Districts</li> </ul>

2.1.2 To maximise children's attainment and development by improving housing conditions	<ul style="list-style-type: none"> <li>Children's Centres to liaise with the local housing authority regarding any concerns with the children's housing conditions.</li> <li>Develop a single point referral system to health related services across Kent for all key agencies involved in Children's Services, for example along the lines of the Thanet system</li> </ul>	the number of properties with children aged 9 months+ where housing action taken
<b>• 2.2 Reduce Risk taking Behaviours in young people</b>		
2.2.1 Continue to implement Kent's teenage pregnancy strategy to reduce teenage pregnancies		<ul style="list-style-type: none"> <li>Reduction in teenage pregnancy</li> </ul>
2.2.2 De-normalise attitudes of smoking among young people		<ul style="list-style-type: none"> <li>Reduce smoking prevalence rates among under 15 year olds</li> <li>Reduce illicit tobacco and supply of tobacco to under 18s</li> </ul>
2.2.3 Improve sexual health by reducing late diagnosis of HIV in Kent and increase Chlamydia screening	<p>A range of targeted work will increase HIV testing</p> <ul style="list-style-type: none"> <li>For Black African women</li> <li>Through MSM to increase early testing</li> <li>in high prevalence areas in Kent</li> </ul> <p>Health care professionals will receive training to broach the topic of risk factors for STIs and work to increase Chlamydia screening in poor performing areas</p>	<ul style="list-style-type: none"> <li>Reduction in late diagnosis of HIV by 1%</li> <li>Increase in take up of Chlamydia screening in <ul style="list-style-type: none"> <li>Primary care</li> <li>In partners</li> <li>In young males</li> </ul> </li> </ul>
<b>2.3 Support older or disabled people to live independently</b>		
2.3.1 Support self management of long term conditions	<p>Assistive Technology normalised in every day service delivery and offered as standard to support choice and control.</p> <ul style="list-style-type: none"> <li>Recognising and making the most of opportunities presented to Public Health from the Integration of health and social care</li> <li>technology that is flexible and diverse enough to support different sectors and communities.</li> <li>Remote conferencing technology enabled consultations reducing trips to out patients</li> <li>Information prescriptions to support people and their carers in the right format at the right time.</li> <li>Training of paramedics and ambulance crews in the principles</li> </ul>	<ul style="list-style-type: none"> <li>People living independently in their own home</li> <li>Number of people accessing enablement and intermediate care services will meet targets</li> <li>All people with LTC will benefit from social care personal budgets, personal health budgets or integrated personal budgets</li> <li>People will feel supported to manage their own condition</li> </ul>

	<p>of telehealth and telecare will support decision making and 24 hr access to telecare and telehealth will reduce transportation rates and subsequent hospitalisation and length of stay</p> <ul style="list-style-type: none"> <li>• People with long term conditions will experience integrated, co-ordinated care in the community and will benefit from personalised interventions which enable them to become experts in their own condition.</li> <li>• Carers of people with long term conditions will have an enhanced quality of life.</li> <li>• New ways of working- Community health and social care services will use risk stratification tools to target support to the right individuals at the right time.</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in admissions to residential / nursing care</li> <li>• Reduction in emergency admissions</li> <li>• Reduction in emergency bed days</li> <li>• Reduction in admissions to residential and nursing care direct from hospital</li> </ul>
2.3.2 Deliver effective local services for falls, falls prevention and fractures	<p>Services are reconfigured and commissioned to prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards</p> <ul style="list-style-type: none"> <li>• acute and primary care-based fracture liaison service</li> <li>• community-based falls clinics</li> <li>• local authority-based postural stability community therapeutic exercise programmes</li> <li>• community/local authority-based falls call-out service(s),</li> <li>• support hospital discharge by developing a referral system to local housing authorities to check housing conditions.</li> <li>• To work in partnership with Home Improvement Agencies, Registered Providers and the voluntary sector</li> <li>• Use of 'SWAT' teams to respond to crisis situation and install technology or a combination of technology and 3rd sector sitting service to avoid hospitalisation or residential/care home admission.</li> </ul>	
2.3.3 Provision of adaptations and equipment to the home to prevent accidents with associated costs, and improve quality of life of recipients and carers	<p>Improved joint working and timely delivery of adaptations through the Disabled Facilities Grant. Telehealth and telecare considered automatically in this process</p>	

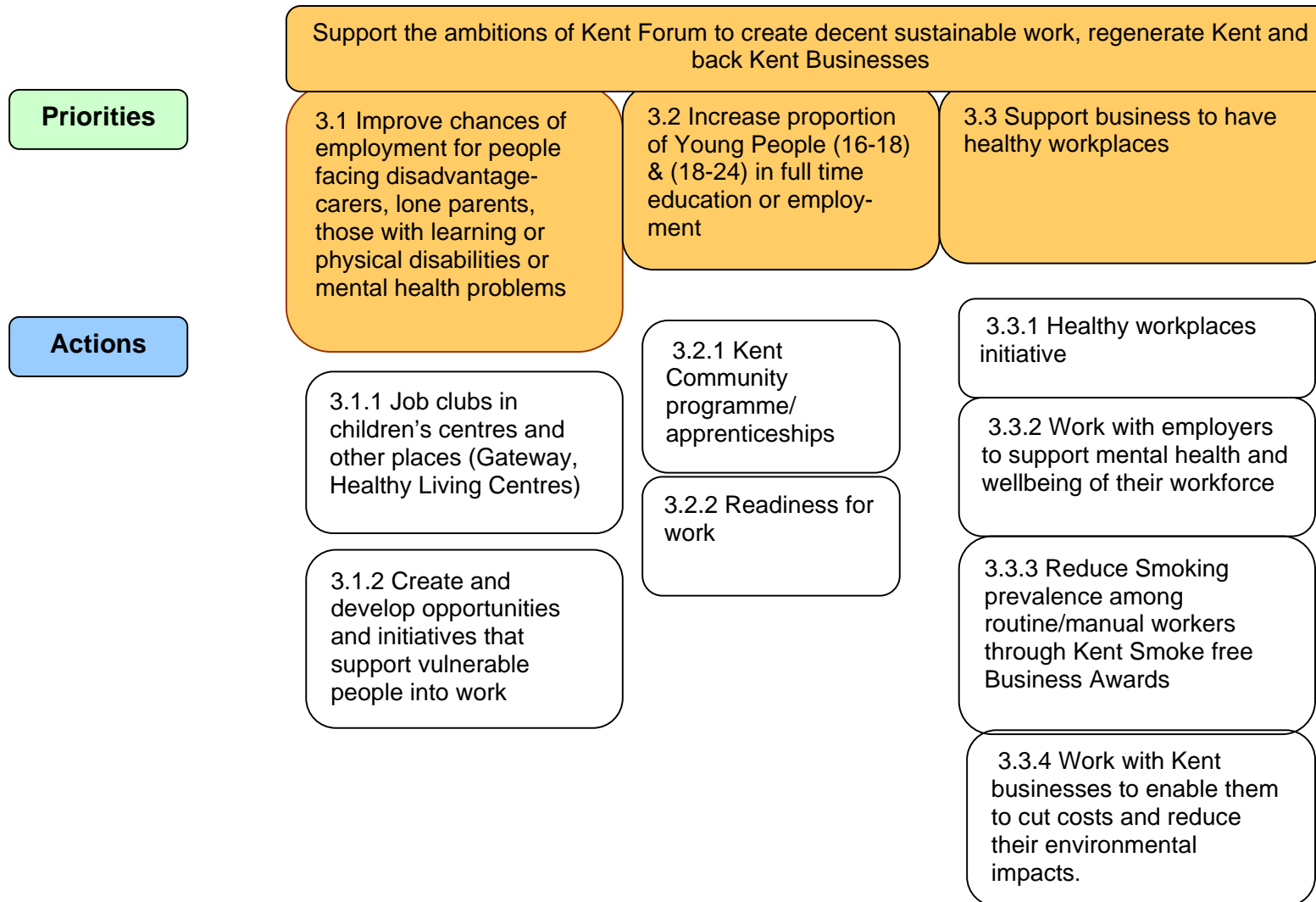
<p>2.3.4 Support people with Learning Disabilities with housing, employment, access to health services and leisure activities</p>	<p>Valuing People Now Partnership continues to work towards</p> <ul style="list-style-type: none"> <li>• ensuring people have more choice and control over what they do during the day</li> <li>• they do not feel excluded from the wider community and its opportunities</li> <li>• finding ways to help people with learning disabilities get real jobs</li> <li>• making it easier to get better housing with appropriate levels of support;</li> <li>• Advocacy is available so that people can communicate their wishes</li> </ul>	
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### 3. Create fair employment & good work for all

The recession is leading to increasing unemployment across Kent. Marmot says that work is good – and unemployment bad – for physical and mental health.

However the quality of work is also important with underlying low levels of stress connected to low paid and insecure work in poor conditions contributing to poorer health outcomes. Work cannot provide a sustainable route out of poverty if job security, low pay and lack of progression are not also addressed

## Objective 3 Create fair employment & good work for all



**Objective 3 Create fair employment & good work for all****Priority 3.1 Improve chances of employment for people facing disadvantage- carers, lone parents, those with learning or physical disabilities or mental health problems**

Disabled workers, those with low or no qualifications and lone parents are among the groups of people most likely to find themselves long-term unemployed. (Begum 2004) With fewer jobs available it is likely that unemployment rates for all vulnerable groups will increase- causing an increase in demand for support from Health, Welfare and Social Care services

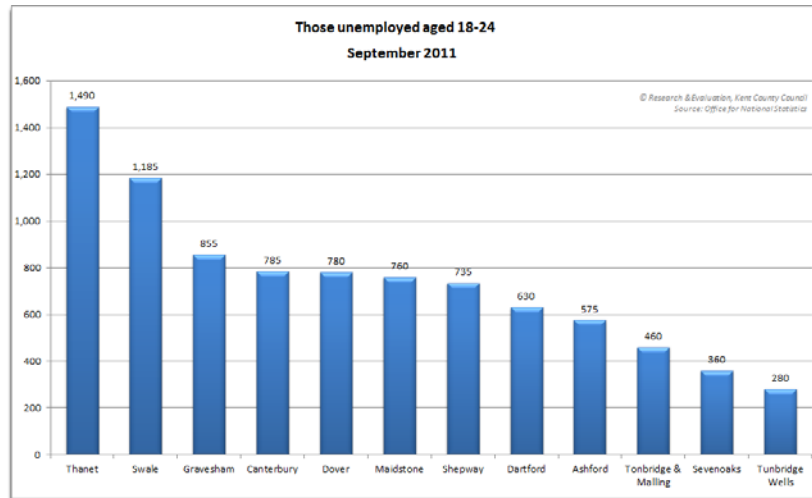
	Eastern and Coastal Kent	West Kent PCT	England Average
% of adults with mental health problems aged 18-69 in contact with secondary mental health services who were known to be in paid employment at the time of their assessment or latest review. 2009	5.2%	5.8%	7.9%

The employment rate for people who are disabled in the KCC area is 51.9%, this is lower than the employment rate for people without a disability which is 78.4% in the KCC area. This is below the South East average rate of 55.7% but above the national average rate of 48.8%.

The difference in employment rates also varies across the KCC area. In Ashford the employment rate for people with a disability is 69.0% and for those without the rate is 79.3%, however in Thanet only 42.2% of disabled people are in employment as opposed to 80.0% of people without a disability.

As of May 2011 nearly 34,000 lone parents were claiming income support. (11,000 men, 22,000 women) Benefit reforms are expected to have the most impact on unemployed, lone, female parents causing them to be worse off financially.

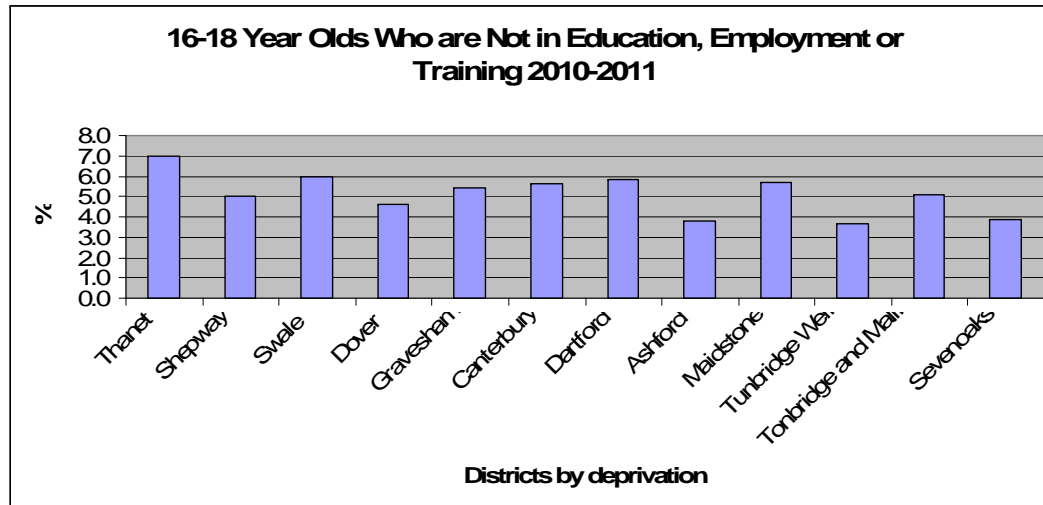
**Priority 3.2 Increase proportion of Young People (16-18) & (18-24) in full time education or employment**



Young people continue to be disproportionately affected by the economic downturn with those aged 18-24 making up the biggest proportion of unemployed in the KCC area. Again areas of deprivation are experiencing the biggest impact and the social gradient can be clearly demonstrated

Research has shown that being NEET between the ages of 16 and 18 is a major predictor of future unemployment, low income, teenage parenting and poor health. Young people who are NEET are also 5 times more likely to enter the criminal justice system, with the life-time cost to the state of each young person who is NEET standing at £97,000.

Kent continues to perform well in decreasing the numbers of young people who are NEET and is below the National and South East average. However performance varies across Districts, with Thanet, Maidstone, Swale and Shepway historically having higher numbers of NEET (16-18). Young people with special educational needs (SEN), offending behaviour, health issues and looked after children (LAC) all perform poorly in comparison with their peers.



**Local Profile**

District comparison to the England average showing where priorities have been identified for local areas.

	Long term unemployment
Ashford	
Canterbury	
Dartford	
Dover	
Gravesham	
Maidstone	
Sevenoaks	
Shepway	
Swale	
Thanet	
Tonbridge & Malling	
Tunbridge Wells	
Kent	

Source: Department of Health. © Crown Copyright 2011'.

**The Aspirations**

Planners and Commissioners should

- i) use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.
- ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively
- iii) Assess impact on health inequalities by applying the Impact assessment tool

Action	What Good will look like in 2015	Targets and achievements
<b>3.1 Improve chances of employment for people facing disadvantage- carers, lone parents, those with disabilities or mental health problems</b>		
3.1.1 Job clubs in children’s centres and other places (gateway, Healthy Living Centres )	Employers have been encouraged/ incentivized to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems	Employment of people with long term conditions
3.1.2 Create and develop opportunities and initiatives that support vulnerable people into work	<ul style="list-style-type: none"> <li>• Maximise opportunities to support people into work through initiatives such as</li> </ul>	Employment of people with mental health

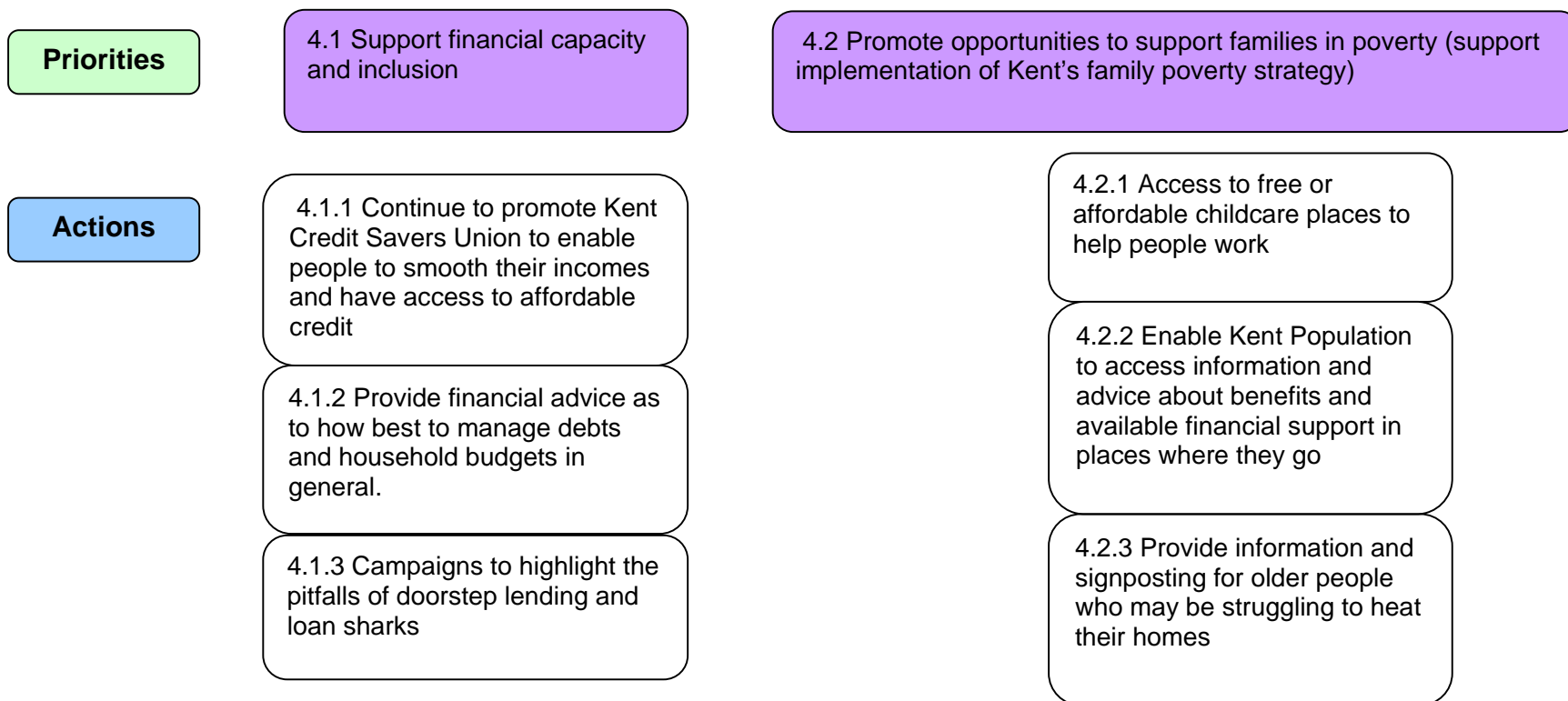
	<ul style="list-style-type: none"> <li>○ Kent Supporting People</li> <li>○ Kent Supported Employment</li> <li>● Support development of Social enterprises with the voluntary sector</li> <li>● Work with employers and service users to support sustainable employment for people with mental health problems</li> </ul>	problems
<b>3.2 Increase proportion of Young People (16-18) &amp; (18-24) in full time education or employment</b>		
3.2.1 Kent Community programme/ apprenticeships		
3.2.2 Readiness for work	<p>Partners have worked with employers to gain an understanding of what skills the employers of Kent want and educational settings have come together to ensure training, work opportunities or further education is targeted to these skills</p> <p>Providing support and advice for 16–25 year olds on life skills, training and employment opportunities, delivered through centres that are easily accessible to young people</p> <p>Kent's number of NEETS remains low</p>	Rate of young people who are NEETS
<b>3.3 Support business to have healthy workplaces</b>		
3.3.1 Healthy workplaces initiative		
3.3.2 Work with employers to support mental health and wellbeing of their workforce	Wellbeing of staff is a priority, especially in the context where many are being made redundant and workloads are increasing.	
3.3.3 Reduce Smoking prevalence among routine/manual workers through Kent Smoke free Business Awards		<ul style="list-style-type: none"> <li>● Smoking prevalence in routine and manual workers</li> </ul>
3.3.4 Work with Kent businesses to enable them to cut costs and reduce their environmental impacts		

## 4 Ensure healthy standard of living for all

*Having insufficient money to lead a healthy life is a highly significant cause of health inequalities*

(Marmot Review 2010)

## Objective 4: Ensure healthy standard of living for all



## Objective 4: Ensure healthy standard of living for all

Financial security is recognised within the Marmot Review as a social determinant of health, specifically through the concept of the 'social safety net'.

The nationwide Health Survey 2010 identified that for both men and women well-being increased with household income. Those on the highest income level scored more than five points higher than those on the lowest income level according to the Warwick-Edinburgh Mental Well-being Scale.

Deprivation is associated with a cluster of health problems including higher levels of unhealthy weight and obesity, physical inactivity, smoking, poor blood pressure control, and other factors that effect physical health. It is also integral to lower educational attainment, lack of employment opportunities, poor housing status, poor access to services, referral differences of practitioners and poor compliance with disease management

### Priority 4.1 Support financial capacity and inclusion

This is particularly relevant now when greater financial responsibility and engagement is being asked of people, whether that is managing care needs in retirement or managing personalised health and social care budgets.

A credit union provides access to fair and affordable credit that allows people to smooth peaks and troughs of income. Conversely, overindebtedness is causing real misery for households and communities. 8 in 10 financially excluded individuals live in social housing.

Poor financial skills can result in debt:

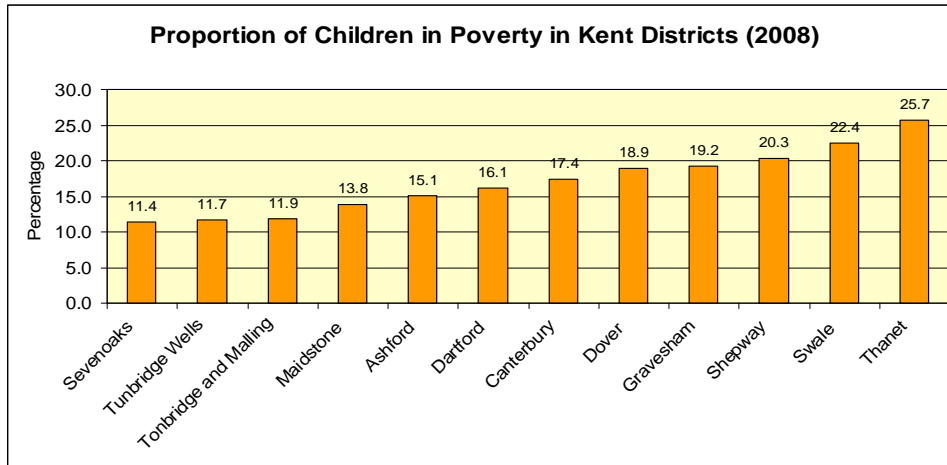
*"It is due to negligence on my part and not having enough experience of handling money when I moved out of my parents' home."*

from A Life in Debt- The profile of CAB debt clients in 2008

### Priority 4.2 Promote opportunities to support families in poverty (support implementation of Kent's family poverty strategy)

The most recent data available at a local level is for child poverty in 2008. This shows 17% of children living in Kent as living in poverty, compared to a national figure of 21%, and equates to over 53,000 children. Within Kent there is considerable variation across districts ranging from 11% in Sevenoaks to 26% in Thanet.

Childcare availability, cost and quality, can be an issue for parents, particularly those of young children. Cost can make low-paid work financially unviable; care is also sometimes not flexible enough, with parents unable to find care for evenings, weekends, at short notice, and in school holidays. In Kent it is estimated that a total of 4,409 additional childcare places are required across Kent and the most significant need for additional places occur within the most deprived areas of Kent.



**Local Profile**

District comparison to the England average showing where priorities have been identified for local areas.

	Deprivation	Proportion of Children in Poverty	Life expectancy - female	Life expectancy - male
Ashford				
Canterbury				
Dartford				
Dover				
Gravesham				
Maidstone				
Sevenoaks				
Shepway				
Swale				
Thanet				
Tonbridge & Malling				
Tunbridge Wells				
Kent				

Source: Department of Health. © Crown Copyright 2011.

## The Aspirations

Planners and Commissioners should

- i) use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.
- ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively
- iii) Assess impact on health inequalities by applying the Impact assessment tool

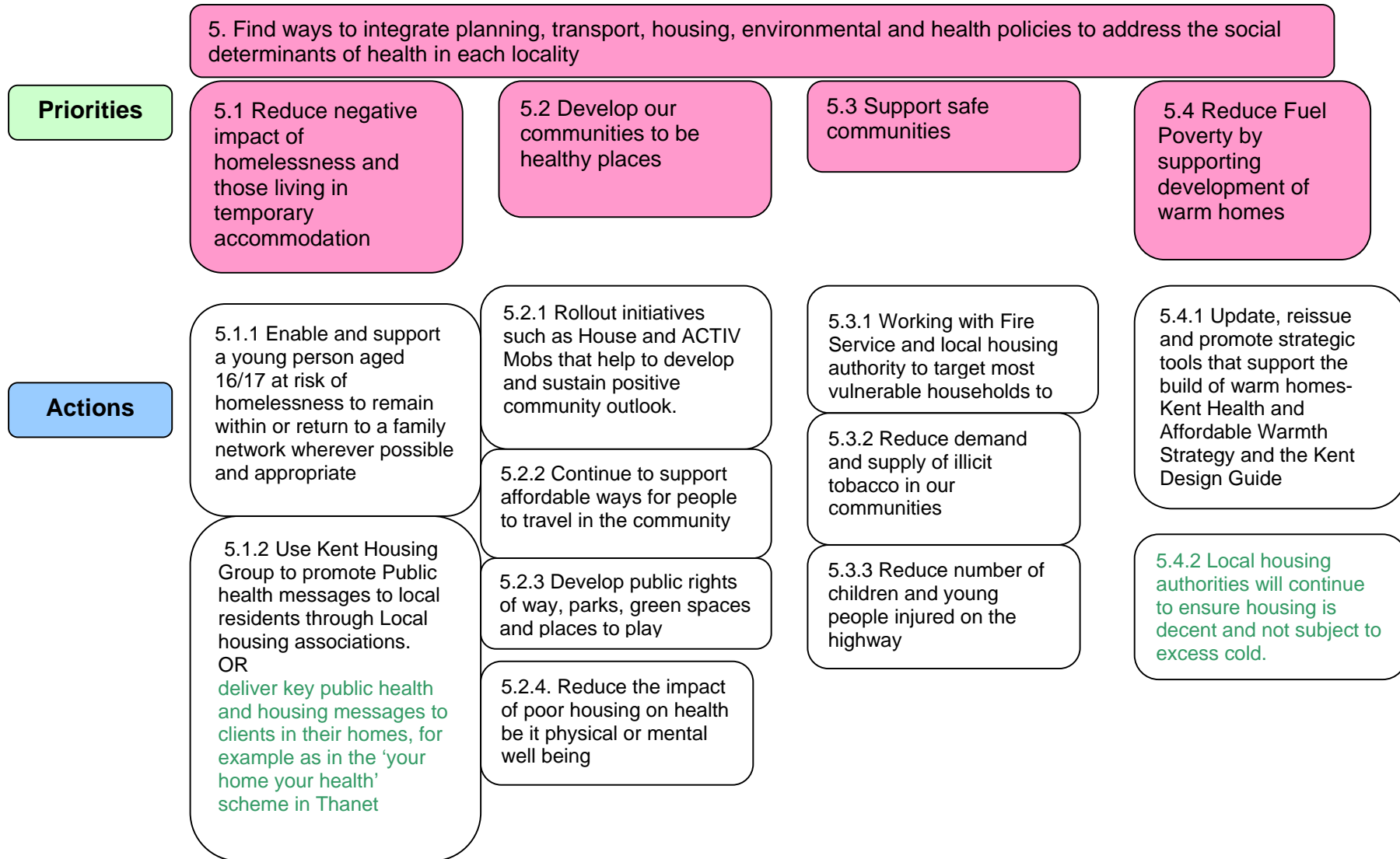
Action	What Good will look like in 2015	Targets and achievements
<b>4.1 Support financial capacity and inclusion</b>		
4.1.1 Continue to promote Kent Credit Savers Union - Kent's credit Union, to enable people to smooth their incomes and have access to affordable credit	Kent credit union is being used by local people with regular promotions to local authority staff and local communities.	
4.1.2 Provide financial advice as to how best to manage debts and household budgets in general	Money management for Vulnerable Young people extended from schools to HOUSE & Youth Hubs – possibly delivered by Healthy Schools Team.  Continue to provide free hosting for CAB at Gateways	
4.1.3 Campaigns to highlight the pitfalls of doorstep lending and loan sharks	Signposting, advice and guidance available from kent.gov.uk and partners sites.	
<b>4.2 Promote opportunities to support families in poverty (support implementation of Kent's family poverty strategy)</b>		
4.2.1 Access to free or affordable childcare places to help people work	Increase in affordable child care places	Reduction of number of children in poverty
4.2.2 Enable Kent Population to access information and advice about benefits and available financial support in places where they go		
4.2.3 Provide information and signposting for older people who may be struggling to heat their homes	Keep Warm in Winter campaign signposting to benefits and energy saving measures	

## 5. Create and Develop Healthy and Sustainable Places & Communities

*Dream with me of a fairer world, but let us take the pragmatic steps necessary to achieve it*

*Sir Michael Marmot October 2011*

## Objective 5: Create and Develop Healthy and Sustainable Places & Communities

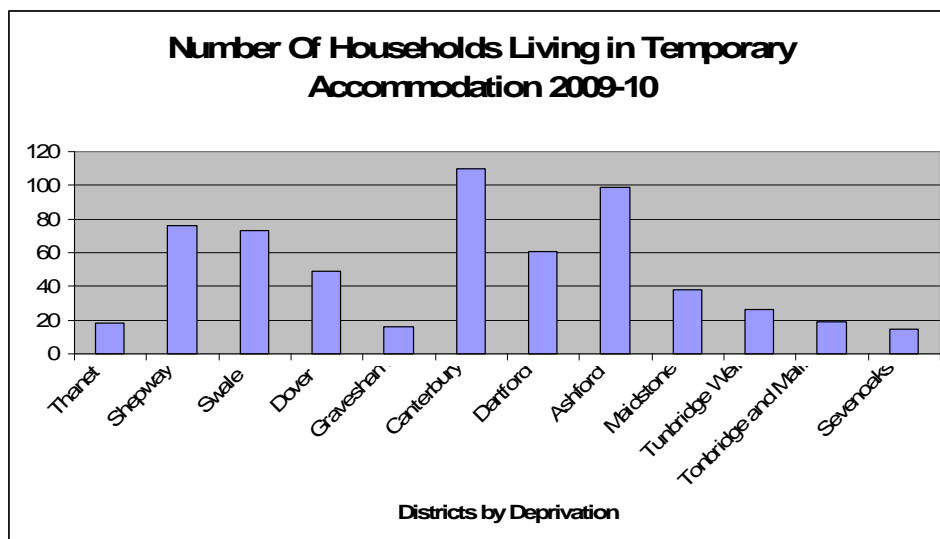


## Objective 5: Create and Develop Healthy and Sustainable Places & Communities

Promoting wellbeing is at the heart of what local government is about: supporting a better life for its citizens and helping to build resilient communities, now and over the longer term

### 5.1 Reduce negative impact of homelessness and those living in temporary accommodation

- The number of households being made homeless is increasing in Kent due to the recession, rising unemployment and cost of living so that families are finding themselves unable to meet the cost of mortgages and rent. From April to June 2011 Kent local authorities made 588 decisions on applications for housing assistance. This is 43% higher than the same quarter in 2010. Of the 588 decisions 229 households were accepted as homeless, an increase of 13% compared to one year ago.
- Districts have made significant improvements from more than 1,800 households living in temporary accommodation in 2004/05 to 583 in 2009/10
- Many homeless young people are placed in temporary accommodation, including Bed & Breakfast. Homeless young people are often very vulnerable, have multiple needs and are in need of support as well as accommodation. Most recent data shows that young people leaving care in Kent (2009-10 data) and young offenders (2008-9) are less likely to find suitable accommodation than is the case nationally and across our statistical neighbours



#### Shelter **Living in limbo:** Survey of homeless households living in temporary accommodation 2004

- Over half of people said that their health or their family's health had suffered due to living in temporary accommodation
- Children had missed an average of 55 school days due to the disruption of moves into and between temporary accommodation
- Two thirds of respondents said their children had problems at school; and nearly half described their children as 'often unhappy or depressed'
- Over three quarters of households (77 per cent) had no family member working. The reasons for this included health or mobility problems, the insecurity of their accommodation, high rents and worries about changes to benefits

### **Priority 5.2 Develop our communities to be healthy places**

Within our county there are health inequalities that are differentiated geographically. Local authorities are the planning authorities for their areas and, as such, have huge opportunities to influence both the infrastructure and the services provided in an area.

In general 20% of households cannot afford a car. Data for Kent shows that 20.5% of lower super output areas in Kent (181 small areas) are within England's most deprived 20% of areas experiencing barriers to housing and services ( home ownership and road distance to key services such as GP, primary school , post office, supermarket). Deprivation related to barriers to housing and services is concentrated in rural areas. This is partially related to the distance people live from services in rural areas but also because of difficulty people in rural areas have entering owner-occupation.

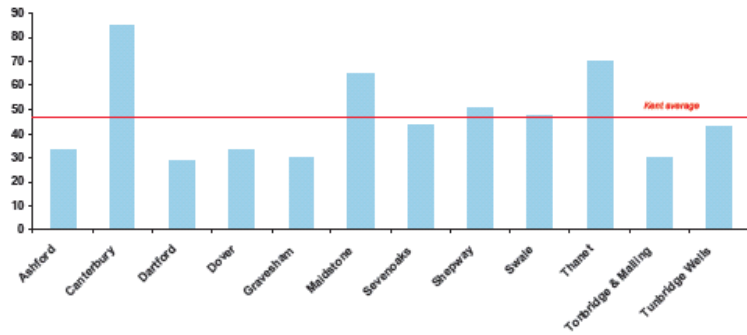
### **Priority 5.3 Support safe communities**

- **Road Safety:** Injury is not only most often the cause of child death in the UK, but also has a steeper social class gradient than any other cause of child death. Casualty rates for child pedestrians are estimated to be five times higher in the most affluent than least affluent wards (Social Exclusion Unit 2003). Traffic calming, design which encourages cycling and discourages car use and parking in the least affluent areas are all part of the contribution local government can make to improving health and reducing health inequalities.
- **Fire Safety:** In 2010-11 Kent Fire and rescue services attended 677 accidental dwelling fires. 2 people died and 77 people were injured as a result of accidental fires. In Kent there are on average 46 fires per year in households and household dwellings caused by smoking. This results in a total cost of £1,150,000 pa in Kent. A child from the lowest social class is nine times more likely to die in a house fire than a child from a well off home.

### **Priority 5.4 Reduce Fuel Poverty by supporting development of warm homes**

Fuel poverty, is said to occur when people in a household need to spend more than 10 percent of their income total in order to heat their home. 6% of households in the KCC area are estimated to be living in fuel poverty. This is approximately 33,000 households. This proportion is higher than the South East average (5.7%) but slightly lower than the national average (6.1%). Of all Kent districts, Thanet has the highest number and proportion of households estimated to be living in fuel poverty, (3,654 Thanet households, which is equivalent to 6.6% of all Thanet households). Dover (6.5%), Swale (6.3%) and Shepway (6.2%) also have a higher estimated proportion of households in fuel poverty compared to the national average.

**Figure 4 - Average annual number of excess winter deaths for all causes for each district in Kent between August 2002 and July 2010**



Source: Kent and Medway Public Health Observatory

The people most likely to die or become ill during the cold weather are those least able to afford to heat their homes. For every one degree Celsius that the outdoor temperature falls below the winter average, there are an 8,000 extra winter deaths in England. This would equate to an estimated 240 deaths across Kent. Living in a cold home can lead to or worsen a large number of health problems including heart disease, stroke, respiratory illness, falls, asthma and mental health problems.

### Local Profile

District comparison to the England average showing where priorities have been identified for local areas.

	Excess Winter Deaths All below average	Road Injuries and deaths- all ages	Violent Crime	Statutory Homelessness
Ashford				
Canterbury				
Dartford				
Dover				
Gravesham				
Maidstone				
Sevenoaks				
Shepway				
Swale				
Thanet				
Tonbridge & Malling				
Tunbridge Wells				

Source: Department of Health. © Crown Copyright 2011'.

## The Aspirations

Planners and Commissioners should

- i) use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.
- ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively
- iii) Assess impact on health inequalities by applying the Impact assessment tool

Action	What Good will look like in 2015	Targets and achievements
<b>5.1 Reduce negative impact of homelessness and those living in temporary accommodation</b>		
5.1.1 Enable and support a young person aged 16/17 at risk of homelessness to remain within or return to a family network wherever possible and appropriate	<p>JPPB to monitor and review Dartford pilot on joint preventative services between housing and FSC children's department re homeless 16/17 year olds and roll out across Kent</p> <p>Fewer young people becoming looked after at age 16/17</p> <p>Reduced dependency on the state at age 19</p> <p>Strengthen positive relationships within family and social networks</p>	Reduction in numbers living in temporary accommodation
5.1.2 Use Kent Housing Group to promote Public health messages to local residents through Local housing associations	<b>Or deliver key public health and housing messages to clients in their homes, for example as in the 'your home your health' scheme in Thanet (kphg)</b>	
<b>5.2 Develop our communities to be healthy places</b>		
5.2.1 Rollout initiatives such as House and ACTIV Mobs that help to develop and sustain positive community outlook.	Relatively small scale interventions designed in partnership with local residents, forming part of wider good quality and sustained neighbourhood working, (family poverty Report recommendation)	House and House on the Move available to young people in town centres
5.2.2 Continue to support affordable ways for people to travel in the community	<p>Increasing active travel across the social gradient and ensure health inequalities are being addressed by this initiative by</p> <p>analysis of postcodes data for purchasing the Kent Freedom Pass and in the future concessionary bus passes.</p> <ul style="list-style-type: none"> <li>• Evaluation and outcomes of Cycle Instruction and Walking</li> </ul>	Take up of Freedom passes, concessionary bus passes.

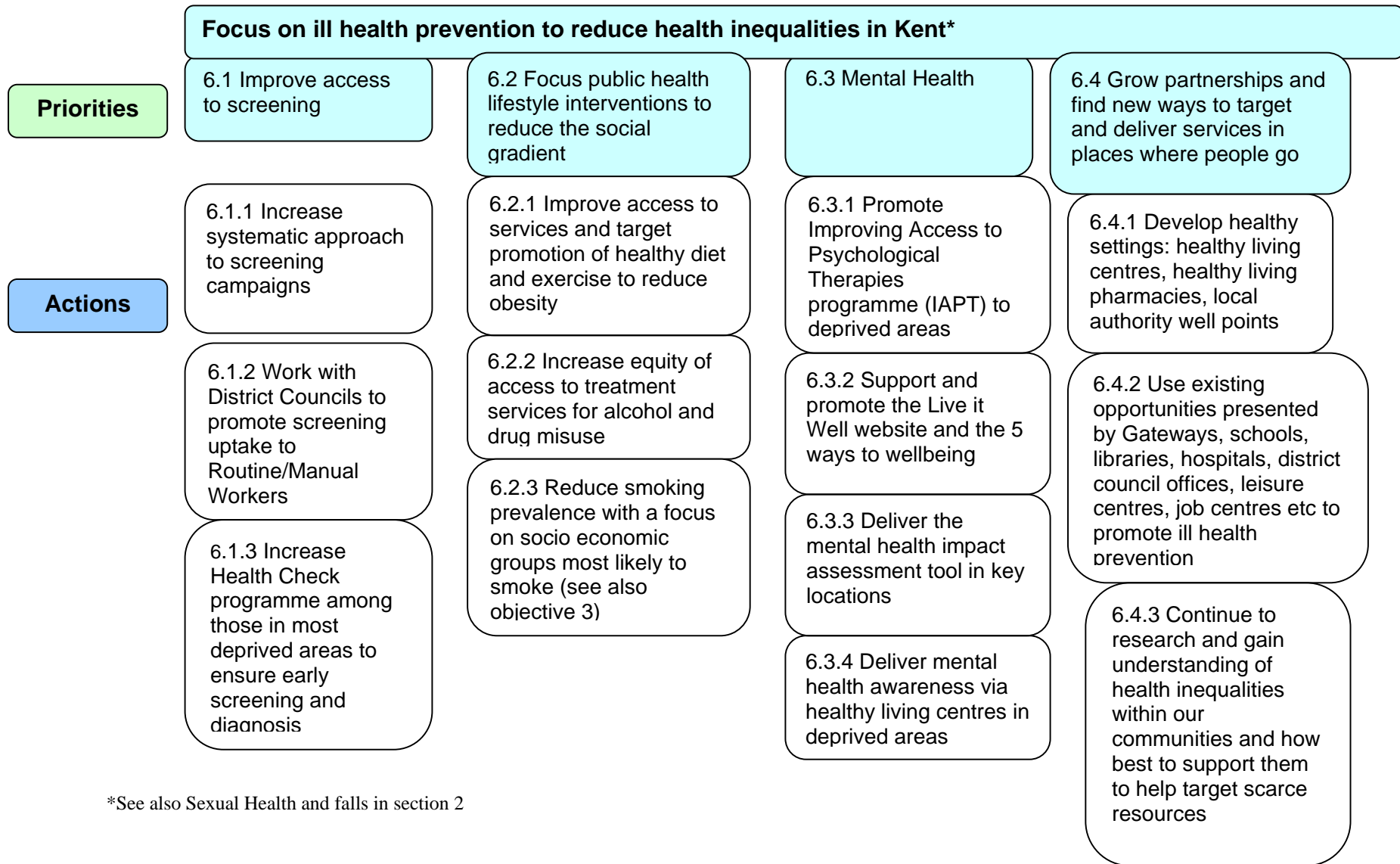
	Schemes targeted to schools in deprived areas, including bike loan/and or repair	
5.2.3 Develop public rights of way, parks, green spaces and places to play	Improving access and quality of public rights of way, open and greenspaces available across the social gradient. Through the Explore Kent website people are signposted to accessible places to go and free events such as guided walking so everyone can get involved	
5.2.4 Reduce the impact of poor housing on health be it physical or mental well being'	<ul style="list-style-type: none"> <li>To reduce the numbers of category 1 hazards for falls related hazards, crowding and space, damp and mould, and carbon monoxide HHSRS hazards in the home.</li> <li>To support a referral system to the local housing authority for raising poor housing concerns.</li> </ul>	Reduce number of homes with serious health and safety hazards
<b>5.3 Develop our communities to be safe places</b>		
5.3.1 Working with Fire Service to target most vulnerable households to reduce risk of fire	Increase the number of above and well above average risk home safety visit referrals from partner agencies Increase No. of sprinkler installations in vulnerable homes	Reduction in accidental fires in dwellings
5.3.2 Reduce demand and supply of illicit tobacco in our communities	Reduction in supply of illicit tobacco	1% Reduction In Smoking Prevalence rate per annum
5.3.3 Reduce number of children and young people injured on the highway	Walking and cycling initiatives, including walking and cycling to school projects and campaigns  Continuing programme of targeted Road Safety projects that have been reviewed and evaluated as effective-e.g. Small Steps – pedestrian training Cycle Instruction B-Viz – campaign to improve visibility especially in winter months  Schools continue to produce and promote travel plans	Reduction in road accidents to children
<b>5.4 Reduce Fuel Poverty by supporting development of warm homes</b>		
5.4.1 Update, reissue and promote strategic tools that support the build of warm	Better/improved joint working between housing and health partners to ensure that homes are warm and safe leading to prevention of falls/COPD/Heart problems, good mental health	Reduction in Excess winter deaths Proportion in fuel

homes- Kent Health and Affordable Warmth Strategy and the Kent Design Guide		poverty
5.4.2 Local housing authorities will continue to ensure housing is decent and not subject to excess cold.	<ul style="list-style-type: none"> <li>• Reduce Category 1 hazards for excess cold (as assessed using the Housing Health and Safety Rating System)</li> <li>• Incorporate energy efficiency into the referral system of key agencies to increase vulnerable residents' access to available grant/discount schemes.</li> </ul>	

## **6. Strengthen the role and impact of ill health prevention**

*Many of the key health behaviours significant to the development of chronic disease follow the social gradient: smoking, obesity, lack of physical activity, unhealthy nutrition.  
(Marmot Review 2010)*

## Objective 6: Strengthen the role and impact of ill health prevention



\*See also Sexual Health and falls in section 2

## Objective 6: Strengthen Ill Health Prevention

### Priority 6.1 Improve access to screening

The aim of national screening is to reduce the amount of disease in a population, or to detect disease at an early stage to improve patient outcome. The most deprived and ethnic minority groups are less likely to take up screening.

The incidence and prevalence of vascular diseases reflect health inequalities in the UK and the widening gaps in life expectancy between the most and the least disadvantaged in society. Gaps in life expectancy across west Kent, for example, can be as high as 14 years. There are also inequalities in the uptake of cervical cancer screening through low uptake amongst younger women with only 69% coverage across Kent for those aged 25-29.

### Priority 6.2 Focus public health lifestyle interventions to reduce the social gradient

**Obesity:** Adult obesity is far more prevalent in socially disadvantaged groups. It is estimated that approximately 28% of the Kent population is obese (354,022).

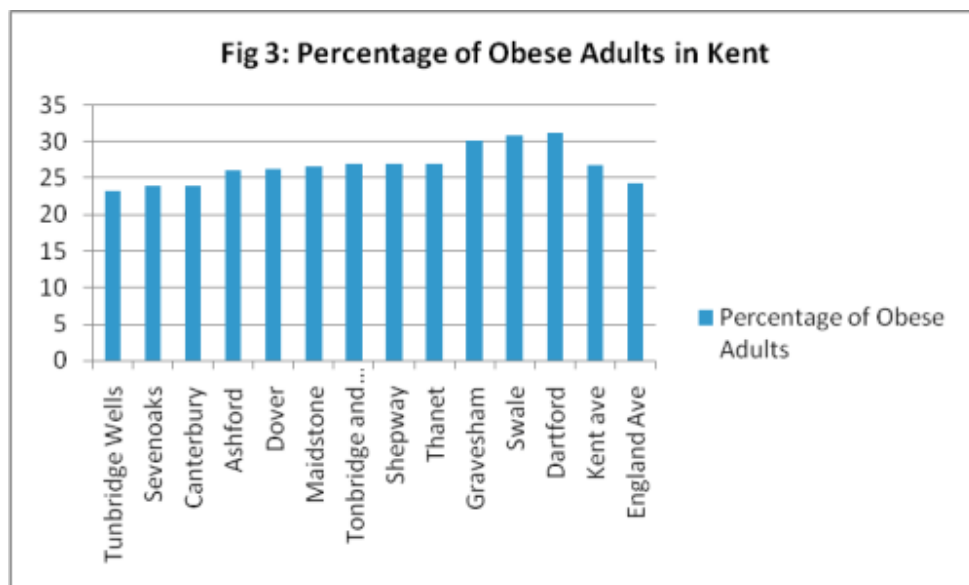


Table 7 Cost burden of obesity to SEC PCTs 2006

PCT	NHS Cost of principle diseases related to obesity (millions)
Eastern and Coastal Kent	279.2
West Kent	221.4

Source: Health Profiles 2010 APHO and Department of Health

**Smoking:** Smoking prevalence in Kent is 24.9%, however there is a significant amount of variation across Kent and it is a major reason for our health inequalities. Routine and manual smokers represent the single biggest group of smokers –half of all smokers belong to the routine and manual group

Of the 11,250 deaths of Kent residents aged 35 and over in 2008, approximately 2,250 (20%) can be attributed to smoking. Approximately 10,300 hospital admissions of Kent residents aged 35 and over in 2008 can be attributed to smoking (5% of the total 205,932 admissions). The majority of these are due to lung cancer, chronic airway obstruction and ischaemic (coronary) heart disease.

**Alcohol Misuse:** The impact of alcohol misuse is widespread; it encompasses alcohol related illness and injuries as well as significant social impacts including crime and violence, teenage pregnancy, loss of workplace productivity and homelessness. Health inequalities are clearly evident as a result of alcohol-related harm; national data indicates that alcohol-related death rates are about 45% higher in areas of high deprivation. It is estimated that 259,103 adults in Kent are drinking at ‘increasing risk’ levels or ‘high risk’ levels. In 2009-10 the equivalent of 24,682 people in Kent were admitted to hospital for alcohol related harm, costing over £45 million.

**Substance Misuse:** There are strong links between levels of deprivation, prevalence of problem drug use, drug related hospital admissions and mortality. Estimates indicate that there are between 3640 and 7591 problem drug users in Kent and that a further 2500 problem drug users are not engaged with services. Hospital admissions continue on an upward trend.

<b>Drug-specific admissions (primary diagnosis) per 100,000</b>	<b>2006/7</b>	<b>2007/8</b>	<b>2008/9</b>	<b>2009/10</b>	<b>2010/11</b>
All Kent	14.21	16.72	10.14	15.81	16.77
East Kent	14.84	17.75	11.36	16.67	18.20
West Kent	12.86	15.26	9.36	14.53	15.79

### **Priority 6.3 Mental Health**

People with mental health problems are more prone to factors that lead to worse health outcomes, such as poor diet, smoking, drug and alcohol misuse and low rates of physical activity. Higher rates of heart disease, stroke, high blood pressure, breast and bowel cancer and diabetes are experienced by people with a serious mental illness. The Mental Health Joint Strategic Needs Assessment for Kent and Medway estimates that there are more than 60,000 people estimated to have severe mental illness, and around 12,000 people are estimated to have severe and enduring mental illness.

### **Priority 6.4 Grow partnerships and find new ways to deliver services in places where people go**

Reducing barriers so that everyone, but especially those dealing with stigmatization or discrimination is able to access health services as locally as possible.

## Local Profile

District comparison to the England average showing where priorities have been identified for local areas.

	Heart disease & stroke	Early death-cancer All below average	Obese adults	physically active adults	Healthy eating adults	People diagnosed with diabetes	Smoking related deaths	Drug Misuse	Hospital Stays for alcohol related harm	Adults smoking
Ashford										
Canterbury										
Dartford										
Dover										
Gravesham										
Maidstone										
Sevenoaks										
Shepway										
Swale										
Thanet										
Tonbridge & Malling										
Tunbridge Wells										
Kent										

Source: Department of Health. © Crown Copyright 2011'.

## The Aspirations

Planners and Commissioners should

- i) use local intelligence data from the JSNA, health profiles and from local communities to influence service delivery.
- ii) Apply the HINST Diagnostic Tool into the commissioning cycle to ensure interventions are delivered effectively
- iii) Assess impact on health inequalities by applying the Impact assessment tool

Action	What Good Will Look Like in 2015	Targets and achievements
<b>6.1 Improve access to screening</b>		
6.1.1 Increase systematic approach to screening campaigns	<p>There will increasing take up from groups who traditionally do not attend screening. Work will have been undertaken to:</p> <ul style="list-style-type: none"> <li>• review variations in the uptake and coverage of all cancer screening programmes and commission programmes to maintain national standards and to reduce local health inequalities.</li> <li>• develop commissioning framework for the local implementation of the HPV triage for cervical cancer screening.</li> <li>• support and monitor the implementation of age extension for Breast Cancer Screening Programme.</li> <li>• develop commissioning framework for the local implementation of age extension for Bowel Cancer Screening Programme</li> </ul>	<p>Proportion of aged 53-64 women who have been successfully screened for breast cancer (+ %)</p> <p>Mortality from all cancer, direct age standardised rate for persons &lt;75yrs</p> <p>Increase in numbers of young women taking up cervical screening....</p>
6.1.2 Work with District Councils to promote screening uptake to Routine/Manual Workers		
6.1.3 Increase Health Check programme among those in most deprived areas to ensure early screening and diagnosis	NHS Health Check programme employing more targeted delivery via alternative providers, from non-clinical, non-NHS sites, so that those with the greatest health needs are effectively reached by the programme JSNA	<p>Health checks' are to be provided to people between 40 and 74 years across Kent.</p> <p>With full roll out 880,211 checks are to be delivered across Kent on an annual basis from 2013</p>
<b>6.2 Focus public health lifestyle interventions to reduce the social gradient</b>		
6.2.1 Improve access to services and target	The Health Trainer service had been developed to target those in areas of high deprivation. Pathways from services into lifestyle	Slow the increase in obesity in adults by 1% per annum

promotion of healthy diet and exercise to reduce obesity	behaviour programmes are clear and easily accessible so that people at risk following a health check or coping with chronic conditions where diet and physical activity would make a difference have improved outcomes. Services have been reviewed, are fit for purpose and provide quality interventions.	
6.2.2 Increase equity of access to treatment services for alcohol and drug misuse	<ul style="list-style-type: none"> <li>• Industrialising opportunistic Identification and Brief Advice (IBA) for those at risk through alcohol misuse as part of Healthy Lifestyles services through local authority commissioning for prevention.</li> <li>• Increased awareness and support to veterans regarding substance and alcohol misuse and mental health</li> <li>• For problem drug users structured counselling, intensive family based interventions, practical group work activities and better links with mental health services will be used to develop relevant social skills that increase service users capacity to sustain long term improvements in terms of substance use and their health and social functioning. Recovery focused intensive keyworking will also provide a specific focus throughout the treatment journey (JSNA)</li> </ul>	<p>1% reduction in hospital stays for alcohol related harm per annum</p> <p>1% reduction in drug misuse</p> <p>Commission IBA in a variety of clinical settings for at least 10% of dependent drinkers in Kent, increasing to 20% over the next two years using referral tools and pathways already agreed by commissioners and providers</p>
6.2.3 Reduce smoking prevalence with a focus on socio economic groups most likely to smoke (see also objective 3)	<p>Assessment of risk factors for early identification of people with COPD and Lung cancer has led to more effective targeting of services leading to evidence of smoking prevalence reduced in cohorts:</p> <ul style="list-style-type: none"> <li>- Routine/Manual workers in Kent</li> <li>- Prison population in Kent</li> <li>- Pregnant women</li> <li>- Families who smoke in areas of deprivation</li> </ul> <p>Stop smoking services should aim to treat at least 5% of the local smoking population each year. In Kent, this equates to at least 14,000 smokers</p>	<p>1% reduction per annum smoking prevalence rates</p> <p>Rate of deaths attributable to smoking in all persons aged 35+</p> <p>Mortality from lung cancer directly ASR for persons &lt;75*+slope index</p>
<b>6.3 Mental Health</b>		
There is an embedded approach across partners to improve mental well-being that also addresses the broader determinants of mental health and can measure the impact of changes to well being. There can be no health without mental health and those experiencing stigma or discrimination will be supported.		
6.3.1 Promote Improving	Training for staff and access to new or improved services to help	

Access to Psychological Therapies programme (IAPT) to deprived areas	children, young people and adults with depression or anxiety within their own communities.	
6.3.2 Support and promote the Live it Well website and the 5 ways to wellbeing		<a href="http://www.liveitwell.org.uk/">http://www.liveitwell.org.uk/</a>
6.3.3 Deliver the mental health impact assessment tool in key locations	Mental Wellbeing Impact Assessment (MWIA) enables local service commissioners and community organisations to assess and measure the impact of their interventions on their population's mental health and wellbeing. It will provide an effective approach to creating policy and services that have the best possible impact on mental well-being	
6.3.4 Deliver mental health awareness via healthy living centres in deprived areas		
<b>6.4 Grow partnerships and find new ways to target and deliver services in places where people go (Asset based community development)</b>		
6.4.1 Develop healthy settings: healthy living centres, healthy living pharmacies, local authority well points	Partner organizations including the 3rd sector come together to tackle broad health issues within a community. Such Hubs promote good health and well being by encouraging healthy lifestyle choices and provide tailored support, advice and guidance to tackle local issues, such as debt, family relationships etc	
6.4.2 Use existing opportunities presented by Gateways, schools, libraries, hospitals, district council offices, the 3 <sup>rd</sup> Sector, leisure centres, job centres etc to promote ill health prevention	Partnerships and links are working between different organisations across the public and voluntary sectors, and different departments to deliver access to health services and information in places where people feel comfortable and experience positive interactions with services	
6.4.3 Continue to research and gain understanding of our communities and how best to support them to help target scarce resources	More accurate understanding of prevalence by district has influenced commissioning of targeted services leading a reduction in the social gradient (the gap has narrowed between the health of the richest and the poorest)	

