AGENDA

WEST KENT CCG HEALTH AND WELLBEING BOARD MEETING

Date: Tuesday 20 December 2016
Time: 4.00 pm
Venue: Tonbridge & Malling Borough Council.

Continued Over/:

Issued on 12 December 2016

The reports included in Part I of this agenda can be made available in **alternative formats**. For further information about this service, or to arrange for special facilities to be provided at the meeting, **please contact Yvonne Wilson** on 01732 375251.

Kent County Council, Policy and Strategic Relationships, Room 2.65, Sessions House, Maistone, ME14 1XQ

7. **Addressing Health Inequalities in West Kent** 29 - 130

Public Health Overview
Update on District & Boroughs Health Inequalities Action Plans
NHS West Kent CCG New Models of Primary Care
Delivering the Five Year Forward View (Sustainability & Transformation Plan)
Malti Varshney
District and Borough Councils
Gail Arnold
Chair

8. **Delivering the Five Year Forward View** 131 - 135

Workforce Development & Role of Make Every Contact Count (MECC)
Tristan Godfrey
Kevin Driscoll

9. **Kent Health and Wellbeing Board**

- Feedback
- Issues to be addressed by the West Kent Health and Wellbeing Board

Cllr Roger Gough
Chair

10. **Update: Obesity Task & Finish Group** 136 - 141

Cllr Lynne Weatherly/Jane Heeley

11. **Any Other Business - Future Agenda Items**

Update: Total Place Resource - Emerging Work in West Kent between NHS WK CCG and KCC
Chair

Update: Task & Finish Groups:

- Progress Report on Delivering Self-Care, Self-Management Strategy
- Frail and Elderly People
- Alcohol Related Harm

12. **Date of Next Meeting**

21 February 2017 - Maidstone Borough Council

13. **West Kent Health & Wellbeing Board Meetings 2016 - 2017:**

- 18 April 2017 – Sevenoaks District Council

Proposed Future Meeting Dates 2017 -2018

- **20 June 2017**
- **15 August 2017**
- **17 October 2017**
- **19 December 2017**
- **20 February 2018**
- **17 April 2018**

WEST KENT CCG HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON TUESDAY 18 OCTOBER 2016

PRESENT:

Bob Bowes	Chair, NHS West Kent Clinical Commissioning Group (NHS WK CCG)
Alison Broom	Chief Executive, Maidstone Borough Council (MBC)
Malti Varshney	Public Health Consultant, Kent County Council, NHS WK CCG
Gary Stevenson	Head of Street Scene, Tunbridge Wells Borough Council (TWBC)
Lesley Bowles	Chief Officer Communities & Business, Sevenoaks District Council (SDC)
Dr Caroline Jessel	NHS England (NHS E)
Dr Andrew Roxburgh	GP Governing Body Member, NHS WK CCG
Cllr Pat Bosley	Sevenoaks District Council
Steve Humphrey	Director of Planning, Housing & Environmental Health, Tonbridge & Malling Borough Council (TMBC)
Penny Graham	Volunteer, Healthwatch, Kent

IN ATTENDANCE:

Nazima Chauhan	N HS WK CCG
CLIC Trainee	NHS WK CCG
CLIC Trainee	NHS WK CCG
CLIC Trainee	NHS WK CCG
Kas Hardy	PH KCC
Dave Holman	NHS WK CCG
Heidi Ward	TMBC
Helen Wolstenholme	TWBC
Yvonne Wilson (Minutes)	NHS WK CCG

13. WELCOME AND INTRODUCTIONS

Chair, Bob Bowes welcomed all present to the meeting.

There were no declarations of pecuniary interests made.

Apologies were received from:
Gail Arnold, Mark Lemon, Dr Sanjay Singh, Dr Tony Jones, Cllr Roger Gough, Cllr Maria Heslop, Cllr Lynne Weatherly, Julie Beilby had advised a Substitute – Steve Humphrey to attend.

14. MINUTES OF THE PREVIOUS MEETING - 5 JULY 2016

Declaration of Disclosable Pecuniary Interests

There were none declared.

Minutes of the Previous Meeting – 5 July 2016

The minutes of the previous meeting were agreed as a true record.

15. MATTERS ARISING

There were no matters arising which were not included as items on the agenda, nor reflected in the Forward Work Programme.

16. ASSURANCE FRAMEWORK

Malti Varshney introduced the report which provided members with an opportunity to examine the West Kent position in relation to progress against a limited number of the Joint Health and Wellbeing Strategy Indicators:
Outcome 1 – Every child has the best start in life
Outcome 2 – Effective prevention of ill health by people taking greater responsibility for their health and wellbeing and
Indicator 3.9, reducing the number of hip fractures for people aged 65 and over (as requested by the Kent Health and Wellbeing Board).

Ms Varshney highlighted the eight indicators outlined in section 3 of the report, where West Kent performance was rated 'Red' suggesting performance is below an acceptable level in comparison to the Kent average or National figures and invited comments from members of the Board on the following specific issues:

- Increasing Slope Index showing there was little success in addressing inequalities amongst men
- Figures showed 2/3 of the population with excess weight
- Breast and Cervical cancer screening is decreasing in certain districts (this was of particular concern, as there was evidence from research of a link between deprivation and 'health enhancing behaviours'
- There was particular concern regarding Hip Fractures and Injury due to falls.

The following comments were shared in discussion:

- Where interventions to address falls prevention had been funded, had any evaluation been undertaken to understand the impact /increase in falls?(Cllr Bosley)
- There were different parts of the system commissioning interventions aimed at addressing falls, there should be consideration on 'joining up' this activity (Malti Varshney)
- The CCG had withdrawn the current Falls Prevention and Postural Stability service. Plans were in hand to enter into discussions about re-procurement (Andrew Roxburgh)

- The Board should consider the scope for examining related areas of activity which may impact on these indicators. There was scope for the CCG to assess the Right Care Packs (which provided a focus on variation between activity in West Kent in relation to similar populations and assisted the focus on local areas where intervention, might be necessary. It was suggested that pathways for musculo-skeletal conditions and osteoarthritis might be useful starting points
- It was reported that the Board had undertaken a depth review of this issue in the past, concern was expressed about the outcome of that activity – need to re-visit (Alison Broom)
- In the last 3 years, the position had been very different as West Kent districts had been held up as exemplars (Bob Bowes)
- The Alcohol Task & Finish Group had met recently to review its action plan and had agreed to focus attention on the development of specific measures for assessing improvement. Each action within the Strategy Plan had an identified 'owner/lead agency' and they were being supported to look at what data sets were available and the scope for examining integrated data sets (Kas Hardy)
- The role of the Local Children's Partnership Groups was vital in terms of work with children and young people to influence prevention and early education, the Board needed to ensure good dialogue on these issues (Cllr Bosley)
- There was also a need to reflect on the complexity of the issue and also to consider the need to address other related issues such as balance, social isolation, depression – Tai Chi, Dance are both activities that could be of benefit. (Caroline Jessel)

The Board resolved:

1. **To commission a time limited piece of work to explore the 'story' behind the West Kent falls and hips and fractures position and recommend a series of actions to be implemented. That this work to include:**
    - **Review of the Board's previous work and the outcomes identified and achieved**
    - **Exploration of Right Care Packs and links between local variation and outcomes**
    - **Assessment of current Health Pathways and review of potential for improving outcomes by considering the scope for reflection on socially determined interventions as part of the care/support offer (wider determinants interventions, self-care; self-management and social prescribing options)**
    - **Explore opportunities for work with relevant strategic partnership groups, agencies, commissioning bodies and population groups to address issues which analysis demonstrates persistent challenges for West Kent.**
2. **To encourage its existing Task & Finish Groups orientate their delivery and action plans towards addressing outcomes where there are concerns for West Kent performance as outlined in sections 3 of the report considered by the Board**
3. **That the Chair to write to the lead for Alcohol Services in KCC**

17. COMMISSIONING CHILDREN'S SERVICES - OUTLINE PROPOSALS & PROSPECTS

Karen Sharp, KCC was unable to attend the meeting for the presentation. Dave Holman , Head of Mental Health, Children's and Maternity Services and Nazima Chauhan NHS West Kent CCG Senior Commissioning Manager for Children & Maternity Services were in attendance for this item. Mr Holman gave a presentation to the Board which highlighted the key areas of activity and the proposed timetable for commissioning children's, mental wellbeing services and outlined work on a national maternity services pilot which was likely set to transform the scope and character of existing services.

The presentation highlights included a focus on:

- Facts & Figures (117,000 children & young people aged between 0-19, 23,000 are between 0-4 years old and that children & young people account for approximately 25% of total West Kent CCG population)
- Strategic Fit
- Levels of Need
- Vision and Guiding Principles for the NHS WK CCG Commissioning Plans for Children's Services 2016 – 2021
- Governance Structure
- Provider Landscape
- Outcomes for Children – West Kent Position

Mr Holman advised the Board of the work currently underway to progress the National Maternity Pioneer which followed a National Review of Maternity Services under the chair of Baroness Cumberledge. The following local agencies were involved in Wave One of the initiative:

- West Kent CCG
- High Weald Lewes Havens CCG
- Maidstone & Tunbridge Wells NHS Trust

Mr Holman explained that as one of seven areas selected nationwide, local health organisations will work with NHS England to develop and test new approaches for improving maternity care and promote their national adoption. Mr Holman signalled the commitment to include a focus on prevention; opportunities to highlight life-style and behaviour change and to enable a real transformation in the scope and character of local maternity services.

Mr Holman reported on current work streams in 2016/2017:

- Service model for Special School Nursing Service - *CCG*
- Community Paediatric Continence Service - *CCG*
- Children's Community Nursing Service - *CCG*
- Therapy Services - *CCG*
- Review of acute pathways - *CCG*
- Commissioning of services for children and young people with special educational needs or a disability – *CCG and KCC*

Current Procurements:

- School Public Health Nursing including emotional health and wellbeing – *Kent County Council*
- Child and Adolescent Mental Health Services – *Kent County Council and CCG*
- Health Visiting Service – *Kent County Council*
- Family Weight Management – *Kent County Council*

Mr Holman concluded the presentation by inviting Board members to consider three key questions:

- Is our focus on commissioning priorities correct?
- Options for future integrated commissioning arrangements?
- Role of the West Kent Local Children's Partnership Groups?

Comments and Discussion

- Local data shows challenges for West Kent on MMR and Obesity outcomes. Recommended that this information should be considered when developing joint commissioning plans. (Malti Varshney)
- How will prevention and social prescribing fit into this agenda (Alison Broom)
- LCPGs are developing well and 'have feet on the ground' and are enthusiastic to have been provided with Outcomes Dashboard. Consideration could be given to delegating responsibilities to them (Bob Bowes)
- KCC was in the process of having good dialogue/negotiation with Districts and Boroughs on a clearer model on the shape of future public health activity (Alison Broom)
- What opportunities could be developed to establish better development of local services and approaches especially in light of the STP/Delivering the Five Year Forward View (Bob Bowes/Alison Broom/Dave Holman)

The Chair thanked Mr Holman and Naz Chauhan for the presentation and requested that the slide presentation pack be distributed to Board members.

The Board resolved to:

1. **Invite KCC and NHS WK CCG to present a detailed written report on progress and plans for closer co-operation in the Commissioning of Children's Services in time for the next Board meeting on 20/12/16.**
2. **Explore invitation for District and Borough representation onto the newly established NHS WK CCG Children's Programme Oversight Group.**

18. UPDATE: IMPLEMENTING THE HEALTH AND WELLBEING BOARD ANNUAL REPORT RECOMMENDATIONS

The Chair provided a brief update on progress towards addressing the recommendations emerging from the Board's Annual Report.

Officer Development Event 16 August 2016
Bob Bowes reported that the officer event in August had been well – attended with presentations from NHS WK CCG, KCC, District/.Boroughs and Public health. The meeting had identified a range of issues and challenges to progressing effective work in partnership. These were outlined in a report to be distributed to Board members.

Gary Stevenson had participated in the event, and had also given a presenting of the current issues and concerns for boroughs and districts. Mr Stevenson reported that it had been positive to gain a better understanding of the different priorities of the partner agencies. Important issues had included considering:

- what opportunities existed for influencing each other's agendas at an earlier stage
- benefits inherent in being able to put faces and names to job roles of officers in partner organisations when carrying out respective job roles
- need for a two way event to share perspectives on local issues/build better knowledge/understanding of organisational priorities and begin to map out areas of joint interest.

A limited number of suggested actions had been taken forward since the meeting including:

- Chief Officer meetings with the Accountable Officer of the CCG and its Chair with their counterparts in each of the District Borough Councils
- Organisation of Board awayday on 17 January 2017, at which the issues highlighted at the August Officer event would assist in determining the agenda for the Board's development
- The four District/Borough councils were participating in the NHS WK CCG 'Town Hall' event where there would be an opportunity to present to the whole CCG staff group.

Strengthening Relationships Between the Health and Wellbeing Board and the LCPGs
The Chair reported on the dialogue with the Chairs of the LCPGs. Individual contacts were made with each of the chairs and a face to face meeting had taken place. The Chair reported that the LCPG chairs had indicated that support from the Board in relation to providing effective links and requests for reviewing the commissioning of services would help address improving outcomes for children.

Work undertaken by the LCPGs to 'drill down' into priority local issues, e.g., excess weight at Year Reception and Year 6, had shown that interventions

needed to happen earlier to focus on prevention opportunities that could only be delivered by Health Visiting and Maternity staff. This meant that influencing the scope of these services through joined up commissioning was vital – but beyond the scope of the LCPGs themselves – but distinctly possible through the intervention and actions at the Health and Wellbeing Board.

It was resolved that:

1. **The Board note the update.**
2. **The report on the outcomes from the Officer event to be distributed to the Board members.**

The Chair to continue to facilitate connections with the LCPGs which assist positive outcomes for children across West Kent

19. DELIVERING THE FIVE YEAR FORWARD VIEW

Kent & Medway Sustainability & Transformation Plan

The Chair updated Board members of the progress regarding development of the Sustainability & Transformation Plan for the Kent & Medway footprint. The Chair reported a challenging situation regarding financial sustainability with a £100m deficit in the current year. The STP had therefore included a series of measures with a focus on:

- Delivering 'quick wins' on prevention (falls; blood pressure prevention; self-care and patient expertise)
- Transforming hospital care (considering the development of centres of excellence and possible hospital re-configuration)
- Local Care (with services offered out of hospital in community settings; development of GP Federations and clusters of practices formed around populations of around 50,000 patients supported by enhanced care/support teams which will demand closer relationships with local councils).

Comments and Discussion:

- Earlier engagement with the STP process would have been helpful (AB)
- Need to seize opportunities to have discussion with boroughs and districts about assets and plans for 'places' as soon as possible as local councils can help the developments towards 'GP clusters and hubs' happen through their planning, Local Plan role (AB, SH)
- Presentation to the Board on the 'West Kent Deal' would be helpful(LB)
- NHS WK CCG Town Hall event planned for 10 November, with District and Borough council officers from the 4 local councils presenting to all CCG staff as part of a process aimed at strengthening working relationships between officers and Executive members (MV)
- Planning for *health* in local communities is important to help shift the burden away from *healthcare services* towards *'health creating assets'* - based thinking that's more focused on creating healthy societies (Dr CJ)

It was resolved:

1. **That Chair, Bob Bowes would support the development of the Federations to encompass the establishing of cluster structures and conversations between GP leaders and District and Borough councils.**
2. **District and Borough Council Chief Officers to be invited to meet with CCG Governing Body members to discuss the 'West Kent Deal'**

NHS West Kent Clinical Commissioning Group Primary Care Strategy

Bob Bowes gave a brief outline of the NHS WK CCG Strategy for transforming Primary Care focusing on specific aspects of the presentation slides 'A Vision for a Vibrant and Sustainable Future For Out of Hospital Services in West Kent 2016 – 2021'.

Dr Bowes explained that plans for the future include networks of practices are working together in *Multisystem Community Providers*; integrated with care teams from community, secondary care, social care and the voluntary sector. New structures and workforce models will allow clinicians to spend more time with their patients, greater continuity of care and higher quality care. Dr Bowes reported that the new ways of working will allow easy access to the right clinician at the right time, and for patients with complex needs proactive management in the community by a wider multidisciplinary team headed up by their GP and appropriate specialist. This approach would be underpinned by a shared clinical record.
Dr Bowes outlined a selection of the emerging CCG Work Programme for strengthening primary care:

- Estate Strategy
- Managing demand for general practice services
- Reduce the complexity of reporting
- Develop IT
- Strengthen the workforce; recruitment, training, retention and Make Every Contact Count
- Tackle out of hospital bed capacity/Care homes
- Enhance access to diagnostics
- Build teams of community and complex care nurses
- Mental health provision outside hospital
- Advice from Consultants
- Work with partners to create integrated services

There was consensus in the meeting about the need to enable the development of closer working relationships with district and borough councils and Make Every Contact Count was felt to be an important vehicle for strengthening confidence amongst staff and professional groups.
It was resolved that:
The Board invites Public Health England to attend the Board to give a presentation on Make Every Contact Count.

20. KENT HEALTH AND WELLBEING BOARD

The Chair fed back on issues considered at the Kent Health and Wellbeing Board. The Board was invited to address the following issues:

- Review the West Kent position in relation to hip fracture and falls (Discussed under agenda item 5 Assurance Framework).
- Consider the work emerging from the Kent Estates Strategy
- Board is to seek assurance on the outcomes reflected in the local Obesity Strategy (particularly in relation to children)

21. NATIONAL CHILDHOOD OBESITY STRATEGY

Apologies were received from Cllr Lynne Weatherly and Jane Heeley**.**

It was resolved that:

1. **The Task & Finish Group be invited to review the outcomes Identified in the Local Action Plan, following the recent national conference on obesity.**
2. **The Task & Finish Group to assess the implications of the new National Children's Obesity Strategy and identify outstanding issues, issues which will need to be reflected in local delivery plans.**

22. ANY OTHER BUSINESS - FUTURE AGENDA ITEMS

The Board resolved to include the following items on the agenda of the December meeting:

- Update: Health Inequalities Action Plans
- Commissioning Children's Services
- Public Health England Perspective on Delivering Make Every Contact Count

23. DATE OF NEXT MEETING

16.00 – 18.00, Tuesday 20 December 2016, Committee Room, Tonbridge & Malling Borough Council, Gibson Drive, King's Hill, West Malling, ME19 4LZ.

24. WEST KENT HEALTH & WELLBEING BOARD MEETINGS 2016 - 2017:

- 17 January 2017 – Board Development Event, Mercure Hotel
- 21 February 2017 - Maidstone Borough Council
- 18 April 2017 – Sevenoaks District Council

Agenda Item 5

To: **West Kent Health and Wellbeing Board**

Report Authors: **Malti Varshney, Public Health Consultant**
Yvonne Wilson, Health & Wellbeing Partnerships Officer

Date: **20th December 2016**

Subject: **Assurance Framework – Health and Well Being Strategy Outcomes for West Kent**

Summary

This report aims to provide the West Kent Health and Wellbeing Board with progress made in addressing the outcomes 3 (except for falls related information which was reported at the last Board meeting), 4 and 5, set out in the Kent Joint Health and Wellbeing Strategy.

Recommendations

The Board is recommended to:

i. Align outcomes of the current Health and Wellbeing Strategy with the delivery outcomes for the Sustainability & Transformation Plan for Kent & Medway

ii. Explore opportunities for working with relevant strategic partnership groups, agencies, commissioning bodies and population groups to address issues which analysis has presented as showing persistent challenges for performance outcomes in West Kent.

iii. Ensure the Board's existing Task & Finish Groups orientate their delivery and action plans towards addressing outcomes where there are concerns for West Kent performance.

iv. NHS West Kent Clinical Commissioning Group (NHS WK CCG) to work with NHS providers to further consider ways of improving services for people with dementia who are admitted as an emergency.

v. West Kent Health & Wellbeing Board (WK HWB) to both influence and ensure a robust local system for integrated commissioning and provision of care for people with dementia

vi. WK HWB to Ensure robust arrangements are put in place to enable

effective alignment between the National Child Measurement Programme to ensure with the work of the LCPGs

vii. Agree appropriate mechanism for assessing the challenges relating to performance with NHS Health Checks Uptake (which has reduced from the 2014/15 level); Slope index in Inequalities across all four districts in West Kent for males; Alcohol related admissions in some districts has slightly increased from 2013/14; screening for cervical and breast cancer in those districts where there has been a reduction from 2014

viii. NHS West Kent Clinical Commissioning Group (NHS WK CCG) to work with NHS providers to further consider ways of improving services for people with dementia who are admitted as an emergency.

ix. That further investigation be carried out in relation to the Public Health England website description of the West Kent overall rate, and the male rate, as "similar to the benchmark", whereas, they label the female rate as "above the benchmark".

x. Requests that the joint commissioners of the Kent Carers Support Services ensure that contract performance management will include KPI's and evidence that will help us to measure specific outcomes, such as those outlined in Appendix 3.

1. Background

1.1 The Kent Joint Health and Wellbeing Strategy is published by Kent County Council on behalf of the Kent Health and Wellbeing Board and covers the period 2014 – 2017.

1.2 The West Kent Health and Wellbeing Board has committed to take a consistent approach to evaluating delivery against the outcomes in the Joint Health and Wellbeing Strategy and to encourage, influence and promote local progress where challenges to performance are identified.

1.3 At its meeting in October 2016, the West Kent Board considered Outcomes 1 and 2 and reflected on the following indicators where performance across the West Kent area highlighted the need for enhanced focus. The table below, sets out the areas of concern and reports on actions in hand to address the concerns identified.

Outcomes – Indicator Description	Actions Taken / To be Progressed/Outstanding Issues
Childhood Obesity going the wrong direction across all Districts in West Kent.	Local Children's Partnership Group (LCPG) Chairs contacted and requested to consider issues raised in the Assurance Report and to give consideration to how issues might be addressed. LCPG expressed need for greater emphasis to be given in commissioning Health Visiting and Maternity Services so that issues including physical activity, healthy weight, self-care/self-management, infant feeding feature in commissioning specifications and new models of service delivery. NHS WK CCG and KCC Commissioning arrangements for children and maternity services identified as Board agenda items October and December 2016 - for discussion regarding priorities, including those identified at LCPGs above. Obesity Task & Finish Group discussed Assurance issues at last meeting and will provide an update on matters discussed to the December Board meeting. <u>Issues</u> • That robust arrangements are required for the National Child Measurement Programme to ensure effective alignment with the work of the LCPGs. • Mechanism required to ensure an effective focus on prevention and self-care, self-management at a population wide and discrete population group specific level in relation to promoting healthy weight.
There is an increasing gap in slope index of inequalities across all four districts in West Kent for males.	Health Inequalities agenda item agreed for December Board Meeting to provide Board members with an opportunity to understand the 'locality' dimension. Each of the Borough Chief Officer representatives and support officers invited to update the Board on progress in

	delivering actions set out in local Health Inequalities Plans. NHS WK CCG also invited to update the Board on arrangements for addressing inequalities.
Excess weight amongst adult population in some districts in West Kent is above national levels	WK HWB Obesity Task & Finish Group to report on proposals to address this, including recommendations to the Board on further actions and approaches to address this.
Uptake of NHS Health Checks has reduced from the 2014/15 level.	To be considered as part of the Agenda Item on Health Inequalities being considered at the 20 December Board meeting.
Alcohol related admissions in some districts has slightly increased from 2013/14	Strategic conversation planned with Chair of WK HWB and Chair of the Alcohol Related Harm Task & Finish Group. Meeting arranged involving Community Safety Partnership lead officers; council Licensing officers, CCG and KCC commissioners of mental health and alcohol services and KMPT service providers to consider ways of strengthening local partnerships, particularly by promoting improved local engagement from health agencies
Proportion of screening for cervical and breast cancer in some districts has reduced from 2014	This requires further investigation.
Reducing the under-75 mortality rate from respiratory disease considered preventable has increased in a few districts.	This requires further investigation.
Hip Fractures in people aged 65 and over are higher than national rates in some districts in West Kent. Although injuries due to fall in people aged 65 and over in all four districts is higher than the national level	Work stream commissioned and undertaking work to enable the Board to understand the relevant issues and determine what actions may be necessary/are proposed to be put in place.

1.4 Since the last WK HWB meeting the Delivering the Five Year Forward View Sustainability and Transformation Plan (STP) for Kent and Medway has been published. Going forward, the Board must now seek to align outcomes of the current Health and Wellbeing Strategy with the delivery outcomes for the STP. At the Kent Health and Wellbeing Board meeting - Board Members received presentations from CCGs and Social Care outlining progress on

plans for out of hospital and primary care services. The West Kent Board will need to take steps to ensure that it too is able to drive progress in improving outcomes which reflects the contributions from across the health and care system and where appropriate, promotes engagement with the community, voluntary and independent sectors.

2. Joint Health and Wellbeing Strategy

2.1 This report aims to provide the West Kent Health and Wellbeing Board with performance figures on a suite of indicators based on Kent's Health and Wellbeing Strategy focussing on:

Outcome 3 - The quality of life for people with long term conditions is enhanced and they have access to good quality care and support, (except for falls related information which the Board reflected upon at its 18 October meeting. Appendix 1. Section 1.3 contains a brief update on actions taken since the last Board meeting.

Outcome 4 - People with mental health issues are supported to 'live well' Appendix 2

Outcome 5 - People with dementia are assessed and treated earlier, and are supported to live well Appendix 3

3. Exception Reporting

3.1 Outcome 3
Overall performance in indicators for Outcome 3 suggests good progress with the exception to the indicator related to reducing the number of hip fractures for people aged 65 and over which the Board considered at its meeting in October.

3.2 Outcome 4
The increase in the suicide rate, especially for males, was expected following local analysis. (The campaign 'Release the Pressure', was implemented in March 2016 to raise awareness of mental wellbeing and encourage men to seek help when they need it.) The Public Health England website labels the West Kent overall rate, and the male rate, as "similar to the benchmark", whereas they label the female rate as "above the benchmark". This requires further investigation.

3.4 Outcome 5
Due to contractual changes the reporting and collection arrangements across the system have changed and therefore data related to previously agreed indicators is no longer available (Appendix 5). For some of the

indicators, limited data is available but not across all organisations and therefore it is difficult to draw specific conclusions around overall progress for Outcome 5. Across two of the hospitals which serve Kent's population there has been some decline in the proportion of patients identified as potentially having dementia and receiving appropriate assessment (for those aged 75 and over admitted as an emergency for more than 72 hours). This requires further investigation.

3.5 From the available data it appears that good progress has been made in increasing the number of dementia patients on GP registers as a percentage of estimated prevalence.

4. Recommendations

The Board is recommended to:

i. Align outcomes of the current Health and Wellbeing Strategy with the delivery outcomes for the Sustainability & Transformation Plan for Kent & Medway

ii. Explore opportunities for working with relevant strategic partnership groups, agencies, commissioning bodies and population groups to address issues which analysis has presented as showing persistent challenges for performance outcomes in West Kent.

iii. Ensure the Board's existing Task & Finish Groups orientate their delivery and action plans towards addressing outcomes where there are concerns for West Kent performance.

iv. Request NHS West Kent Clinical Commissioning Group (NHS WK CCG) to work with NHS providers to further consider ways of improving services for people with dementia who are admitted as an emergency.

v. Influence and ensure a robust local system for integrated commissioning and provision of care for people with dementia

vi. Seek assurance from the 0-25 Health and Wellbeing Board that robust arrangements are put in place to enable effective alignment between the National Child Measurement Programme to ensure with the work of the Local Children's Partnership Groups (LCPGs).

vii. Agree appropriate mechanisms for assessing the challenges and designing delivery actions relating to performance with NHS Health Checks Uptake (which has reduced from the

2014/15 level); Slope index in Inequalities across all four districts in West Kent for males; Alcohol related admissions in some districts has slightly increased from 2013/14; screening for cervical and breast cancer in those districts where there has been a reduction from 2014

viii. Request that NHS West Kent Clinical Commissioning Group (NHS WK CCG) works with NHS providers to further consider ways of improving services for people with dementia who are admitted as an emergency.

ix. Takes steps to ensure further investigation is carried out in relation to the Public Health England website description of the West Kent overall rate, and the male rate, as "similar to the benchmark", whereas they label the female rate as "above the benchmark".

x. Requests that the joint commissioners of the Kent Carers Support Services ensure that contract performance management will include KPI's and evidence that will help us to measure specific outcomes., such as those outlined in Appendix 3.

Report Prepared by

Malti Varshney, Consultant in Public Health malti.varshney@kent.gov.uk
Helen Groombridge, Performance Officer, Public Health
helen.groombridge@kent.gov.uk
Yvonne Wilson, Health & Wellbeing Partnerships Officer yvonne.wilson10@nhs.net

Key to KPI Ratings used

(G) GREEN	Target has been achieved or exceeded, or in comparison to National
(A) AMBER	Performance was at an acceptable level within the target or in comparison to National
(R) RED	Performance is below an acceptable level, or in comparison to National
æ	Performance has improved relative to the previous period
	Performance has worsened relative to the previous period
	Performance has remained the same relative to the previous period

Data quality note: All data is categorised as management information. All results may be subject to later change.

Outcome 3 - The quality of life for people with long term conditions is enhanced and they have access to good quality care and support

Indicator Description – Available CCG Figures	Target	Previous Status	Recent Status	DoT	Recent Time Period
3.1 Increasing clients with community based services who receive a personal budget/direct budget (ASC KCC)	Unresolved with Adult Social Care KCC				
3.2 Alternative: Increasing the number of adult social care clients receiving a Telecare service (ASC KCC)	5708	5792 (g)	5998 (g)	æ	April 2016

3.3 Increasing the proportion of older people (65+) mostly at risk of long term care and hospital admission, who were still at home 91 days after discharge from hospital in reablement/rehabilitation services (**Stress**. **BCF.** ASCOF, HSCIC)	82.1% (national)	83.8%	84.1%	æ	2014/15
3.4 Alternative: Reducing admissions to permanent residential care (or nursing care) for older people (**Stress**. **BCF.** ASC KCC)	139	121 (g)	121 (g)	æ	April 2016
3.5 Increasing the percentage of adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family (PHOF)					
Persons	73.3% (national)	70.0%	72.4%	æ	2014/15
Male	73.2% (national)	68.2%	71.3%	æ	2014/15
Female	73.1% (national)	72.7%	73.9%	æ	2014/15
3.6 Increasing the percentage of adults who are receiving secondary mental health services on the care programme approach recorded as living independently, with or without support (aged 18-69 years. PHOF)					
Persons	59.7% (national)	77.6%	75.3%		2014/15
Male	58.4% (national)	76.6%	74.6%		2014/15
Female	61.3% (national)	78.7%	76.2%		2014/15
3.7 Reducing the percentage point gap in employment rate between those with a learning disability and the overall employment rate (PHOF.)	66.9% (national)	66.3%	65.0%	æ	2014/15
3.8 Increasing the early diagnosis of diabetes – Recorded Diabetes (registered GP Practice aged 17+. PHOF)	6.4% (national)	6.2%	6.2%		2014/15
3.9 Reducing the number of hip fractures for people aged 65 and over (rate per 100,000. PHOF)	571 (national)	581 (a)	598 (a)		2014/15

Appendix 2

Outcome 4 - People with mental health issues are supported to 'live well'

Indicator Description	Target	Previous Status	Recent Status	DoT	Recent Time Period
4.1 Increasing the crisis response of A&E Liaison within 2 hours	There is a national programme to provide a CORE 24/7 Acute Liaison Services (ALS) by 2021. At present the ALS service runs from 8am-8pm in both Maidstone and Maidstone & Tunbridge Wells NHS Trust (MTW) Accident & Emergency Departments (A & E's). Work is underway to deliver an annual increase to achieve a CORE 24/7 service. At present 91% of referrals (average) from April – Dec 2016 have been seen within the 2 hr target in MTW and 85% within Maidstone hospital. Any urgent referrals that are received, are firstly referred to the crisis team (which is 24/7) but if the crisis team do not see them they are picked up first thing by ALS team, currently all urgent referrals are seen within 24hrs.				
4.2 Increasing the crisis response of A&E liaison, all urgent referrals to be seen within 24 hours					
4.3 Increasing access to IAPT (Increasing Access to Psychological Therapies) services*	Currently there are four key national NHSE targets are reported: 15% access target, achieved (15.6%) 50%+ recovery rate of patients completing treatment and NHSE waiting time standards, achieved 56% 75% of all patients to receive treatment within 6 weeks, currently achieving 96% 95% of all patients within 18 weeks of referral, currently achieving 100%				

4.4 Increasing the number of adults receiving treatment for alcohol misuse (Public Health Kent)**	-	396***	358		October 15 to September 16
4.5 Increasing the number of adults receiving treatment for drug misuse (Public Health Kent)**	-	539***	541	æ	
4.6 Reducing the number of people entering prison with substance dependence issues who are previously not known to community treatment (PHOF)	No longer reported – PHOF have changed their metrics				
4.7 Increasing the successful completion and non-re-presentation of opiate drug users leaving community substance misuse treatment services (ndtms.net) **– KENT LEVEL ONLY AVAILABLE**	6.6% National	8.0% (g)****	7.7% (g)		Completion period: May 15 to April 16

Notes:
*There is also a national initiative to increase the access target to 25% by 2021 through inclusion of Long Term Conditions (LTC), but there is a huge piece of work being done nationally on this at present as it involves a huge recruitment factor and additional training for IAPT providers. In West Kent we are starting a six month pilot on LTC with the pain clinic in April 2017.
**Those accessing KCC commissioned services registered with a West Kent CCG GP.
*** Previous time frame July 2015 to June 2016
****Previous time frame completion period April 2015 to March 2016

Indicator Description	**England**	**Previous Status**	**Recent Status**	**DoT**	**Recent Time Period**
4.8 Increasing the employment rate amongst people with mental illness/those in contact with secondary mental health services (ASCOF)					
4.9 Reducing the number of suicides (rate per 100,000. PHOF)					
Persons	10.1	11.1 2012-2014	11.7		2013-2015
Males	15.8	15.3	16.5		2013-2015

		2012-2014			
Females	4.7	6.9 2012-2014	7		2013-2015
Source - http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0/gid/1938132828/pat/6/par/E12000008/ati/19/are/E38000199					
4.10 Increasing the percentage of adult social care users who have as much social contact as they would like according to the Adult Social Care Users survey (PHOF)					
4.11 Increasing the percentage of adult social carers who have as much social contact as they would like according to the Personal Social Services Carers survey (PHOF)					
4.12 Decreasing the percentage of respondents who according to the Annual Population survey have (PHOF):					
Low Satisfaction (score 0-4)					
Low Worthwhile (score 0-4)					
Low Happiness (score 0-4)					

Outcome 5 - People with dementia are assessed and treated earlier, and are supported to live well
Appendix 3

Indicator Description		Target	Previous status	Recent status	DoT	Recent time period
5.1 Increasing the reported number of dementia patients on GP registers as a percentage of estimated prevalence (South East CSU)		Kent figures are now no longer available – please refer to the CCG table below.				
5.2 Reducing rates of hospital admissions for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1,000. South East CSU)						
5.3 Reducing rates of hospital admissions for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000. South East CSU)						
5.4 Reducing total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000. South East CSU)						
5.5 Reducing total bed-days in hospital per population for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000. South East CSU)						
5.6 Increase the proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who have been (NHS England):						
Dartford and Gravesham NHS Trust	(a) identified as potentially having dementia	To be confirmed	94%	92%		Q1 2016/17
	(b) who are appropriately assessed		98%	95%		
	(c) and, where appropriate, referred on to specialist services in England		unpublished	96%	-	
East Kent Hospitals University NHS Foundation Trust	(a) identified as potentially having dementia		99%	99%		Q1 2016/17
	(b) who are appropriately assessed		92%	95%	æ	

Indicator Description		Target	Previous status	Recent status	DoT	Recent time period
	(c) and, where appropriate, referred on to specialist services in England		unpublished	96%	-	
Maidstone and Tunbridge Wells NHS Trust	(a) identified as potentially having dementia		99%	100%	æ	Q1 2016/17
	(b) who are appropriately assessed		100%	100%		
	(c) and, where appropriate, referred on to specialist services in England		unpublished	99%	-	
Medway NHS Foundation Trust	(a) identified as potentially having dementia		97%	95%		Q1 2016/17
	(b) who are appropriately assessed		100%	96%		
	(c) and, where appropriate, referred on to specialist services in England		unpublished	96%	-	
5.7 Decreasing the percentage of people waiting longer than 4 weeks to assessment with Memory Assessment Services		Data no longer available for this indicator				
5.8 Increasing the proportion of patients diagnosed with dementia whose care has been reviewed in the previous 15 months		No data supplied from either ASC or SECSU				
5.9 Reducing care and nursing home placement, especially those made at a time of crisis and/or from an acute setting						
5.10 Increasing numbers of carers assessments and carers accessing short breaks		No data supplied from either ASC or SECSU*				
5.11 Increasing attendance at Dementia Peer Support Groups		No data supplied from either ASC or SECSU				
5.12 Increasing number of Dementia Champions						

Indicator Description – Available CCG Figures	Previous Status	Recent Status	DoT	Recent Time Period
5.1 Increasing the reported number of dementia patients on GP registers as a percentage of estimated prevalence (South East CSU)				
NHS Ashford CCG	47%	53%	æ	2015/16
NHS Canterbury CCG	47%	64%	æ	
NHS West Kent CCG	47%	56%	æ	
5.2 Reducing rates of hospital admissions for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1,000. South East CSU)				
NHS Ashford CCG	20.1	21.8		2015/16
NHS Canterbury CCG	30.6	28.1	æ	
NHS West Kent CCG	26.4	24.2	æ	
5.3 Reducing rates of hospital admissions for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000. South East CSU)				
NHS Ashford CCG	43.6	47.4		2015/16
NHS Canterbury CCG	63.1	58.2	æ	
NHS West Kent CCG	54.3	49.3	æ	

5.4 Reducing total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000. South East CSU)				
NHS Ashford CCG	187	178	æ	2015/16
NHS Canterbury CCG	188	189		
NHS West Kent CCG	262	265		
5.5 Reducing total bed-days in hospital per population for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000. South East CSU)				
NHS Ashford CCG	403	385	æ	2015/16
NHS Canterbury CCG	394	388	æ	
NHS West Kent CCG	545	544	æ	

Notes: * Kent carers support services are jointly commissioned by KCC and all seven Kent CGG's. The contracts provide carers with a wide range of support including holistic and person centred assessment of their needs, planned short breaks, crisis support, access to information and advice, emotional and practical support, support to access health appointments and signposting to community based support.

The performance management of the current Carers' Support contracts has been linked to Key Performance Indicators (KPI). The KPI's have been particularly focused on ensuring that service provision is 'happening' and at levels that were calculated to show that they were being effective and good value for money. Future contract performance management will include KPI's and evidence that will help us to measure how effectively the support provided to Carers in Kent ensures they are

- respected as expert care partners
- able to access the integrated and personalised services they the need to support them in their caring role.
- able to have a life of their own alongside their caring role
- supported so that they are not forced into financial hardship by their caring role
- supported to stay mentally and physically well and treated with dignity.

The current contracts will end in 2018 and KCC and CCG Commissioners have started to work with service providers and other stakeholders to understand other 'Outcome' benefits that this essential support service for carers provide, including

- How many hospital admissions days/weeks have been prevented.
- How many residential/nursing placements have been prevented or delayed.
- How many hours of homecare support have been prevented.

It is critical that we have a meaningful 'Kent' narrative, with a reasoned rational, that will inform the development of the Kent Carers Support model post 2018. Ensuring carers in Kent to get the support they need to carry on their caring role will help reduce the capacity and financial pressures in Social Care and Health systems

28

Agenda Item 7

Presented by: Malti Varshney, Consultant in Public Health.
Karen Hardy, Public Health Specialist

To: West Kent CCG Health and Wellbeing Board

Date: 20th December, 2016

Subject: Inequalities in West Kent

Classification: Unrestricted

Summary

Health inequalities still persist across Kent and commissioners and providers across the system have a duty to address these. Despite increasing life expectancy across the Kent population, the gap between the most affluent and the poorest communities has not decreased. The most deprived communities in Kent still experience poorer outcomes in education, socio-economic and consequentially in health. This paper outlines the Kent and west Kent picture of inequalities and recommended approach for discussion and decision making by the West Kent Health and Wellbeing Board.

1. Mind the Gap: Inequalities Action Plan for Kent (2016)

Mortality rates across Kent have been falling over the last decade, but the 'gap' in mortality rates between the most deprived and least deprived still persisting. In the more deprived deciles, an increased proportion of the deaths are caused by cardiovascular, respiratory and Gastro Intestinal (GI) disease. It is now widely recognised that our health as individuals is shaped by the conditions in which we are born, grow, live, work and age[i]. Analysis of Lower Super Output Areas (LSOA, with average populations of approximately 650 to 1,500[ii]) undertaken by Kent and Medway Public Health Observatory in June 2016[iii] identified 88 LSOAs across Kent with the most deprivation. Analysis showed common characteristics and the association between poor lifestyles, such as smoking, alcohol, obesity and socio-economic factors and the most deprived communities. Kent Health and Wellbeing Board (July 2016) agreed the revised Public Health Mind the Gap Action plan which outlines a systematic, place based approach, disproportionately targeted at the poorest communities. Of these 88 LSOAs, five are within Maidstone District and two are in Swanley, Sevenoaks (DGS CCG).

2. Health Inequalities in West Kent

West Kent has the largest and relatively more affluent population of the Kent CCGs with only 7 LSOAs (5 in CCG area) identified in the Kent Inequalities Action Plan. Further analysis was undertaken to identify the 28 most deprived wards in the tenth decile for West Kent CCG (which includes the 5 LSOAs that also feature in the Kent most deprived decile). Whilst the majority of the most deprived LSOAs appear in

Maidstone District, six fell within Tonbridge and Malling, three in Tunbridge Wells, and one in Sevenoaks District (Edenbridge) in addition to the two Kent LSOAs which sit within DGS CCG.

Of the 28 LSOAs, the highest number are characterised as type 3 (Mosaic type), families in social housing. Table I provides a snapshot of 28 LSOAs, characteristics and health outcomes:

Table I

Characteristic Type	No of LSOAs	Characteristic Description	Health Outcomes
Type 3	**15**	Families in social housing **Maidstone, Parkwood, Shepway, Edenbridge, East Malling, Trench, Broadwater, Sherwood, High Broom**	• High premature mortality rates • High emergency admission rates • High rates of disability *(activities limited a lot)*
Type 4	**6**	Young people in poor quality accommodation **Maidstone Town Centre, Ringlestone**	• High premature mortality rates • High rates of emergency admissions
Type 5	**5**	Mixed-age social housing mix **Ringlestone, Shepway, Aylesford, Snodland, Trench**	• High premature mortality rates • High rates of disability *(activities limited a lot)*
Type 2	**2**	Deprived rural **Hadlow, Nettlestead Green**	• Average premature mortality • High rates of emergency admissions • High rates of disability *(activities limited a lot)*
Type 1	**0**	High numbers of young adults in private rented accommodation	

From the key characteristics of each LSOA, the analysis identifies focus areas to improve health and wellbeing, the majority of which relate to education and training, qualification, employment, living environment and good affordable housing.

3. Current performance to address Inequalities through Public Health programmes

3.1 NHS Health Checks

NHS Health Checks are free to those aged between 40 and 74 without an existing diagnosis, to identify signs and symptoms to reduce the risk of developing diseases such as diabetes, heart disease, kidney disease, stroke and dementia. NHS Health Checks are available through GP practices and community settings in most of the West Kent CCG area. In addition to identifying risk or providing early diagnosis, NHS Health Checks can be a useful tool to motivate behaviour change. Performance monitoring of NHS Health Checks in West Kent CCG for 2015/16 shows:

- 27,987 patients eligible for Health Checks in 2015/16
- 29,114 invitations sent
- 11,109 Health Checks completed (39.7% of eligible population)
- Practice completion rates ranged from 9.5% to 102.5% of eligible population (Table 2) (Agreement between Public Health and GP practices to invite outside of the annual eligible population)

Table 2 Percentage of NHS Health Checks completed

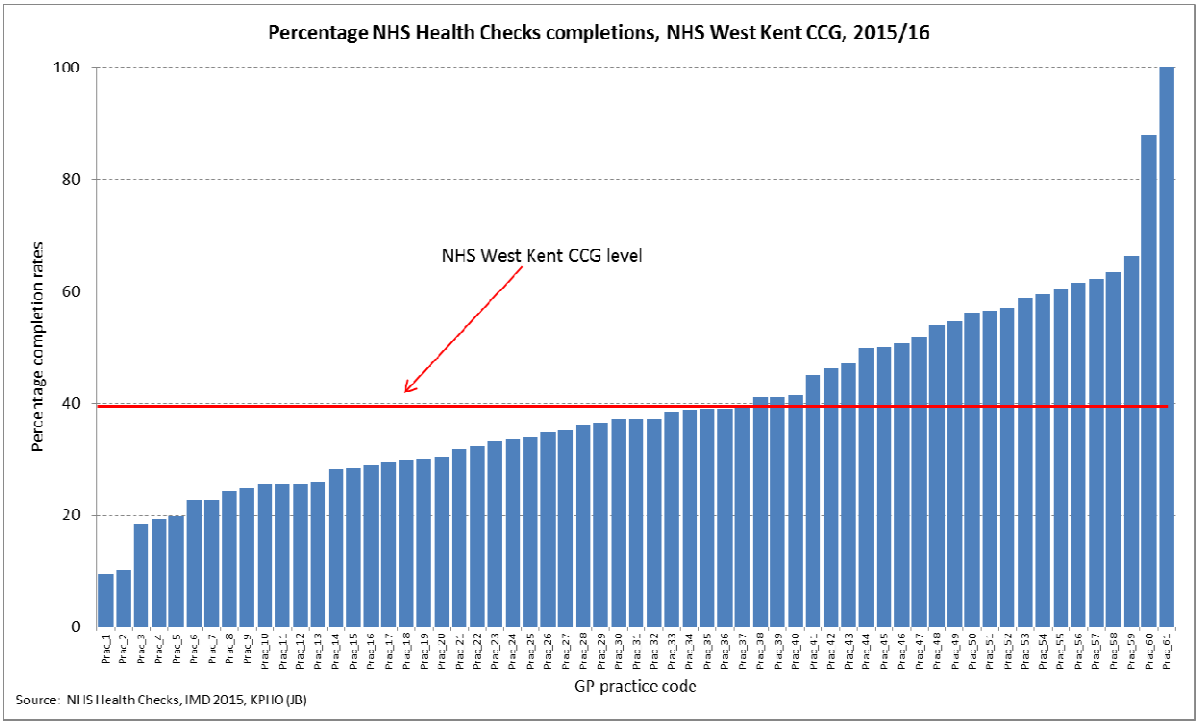
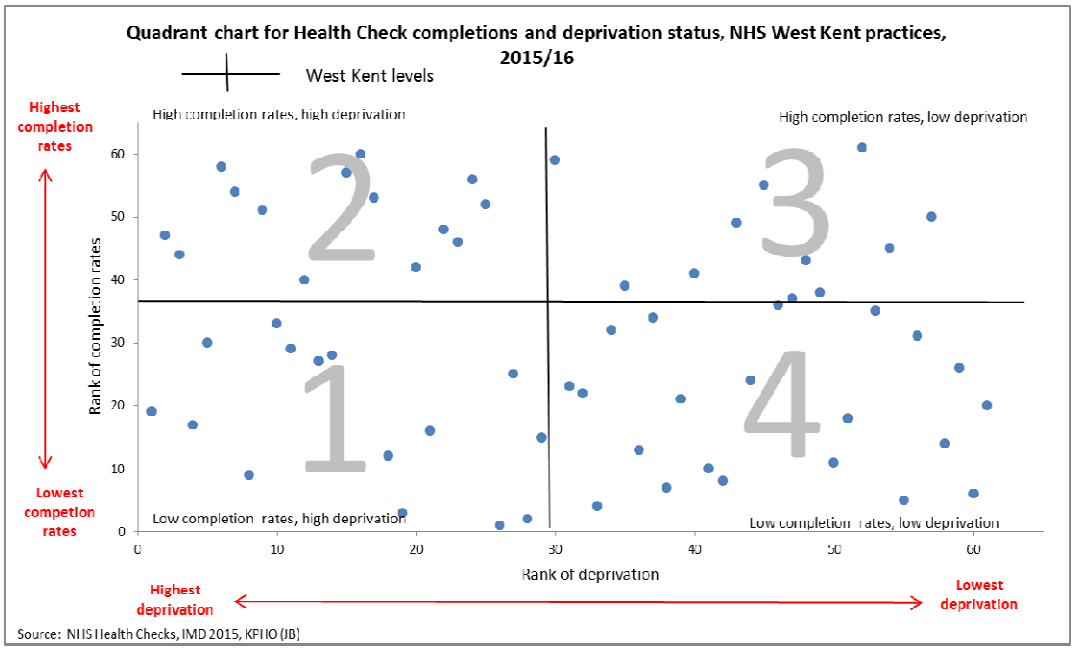


Table 2 shows the variation rates between GP practices, with some achieving maximum completion of health checks to the eligible population, whilst over half of the practices are below the West Kent CCG average rate. The correlation between completion rates and deprivation shows that there are slightly more NHS Health Checks completed in deprived areas, but to address inequalities we need to increase performance in the lowest deciles of deprivation (Table 3).

Table 3 Correlation between completed NHS Health Checks and deprivation



Smoking

Data analysis of 47* West Kent CCG practices found that of those referred into Smoking Cessation services:

- 1051 quit dates set for these 47 practices
- 545 successful quits, indicating 51.8% successful quits
- Successful quit rates ranged from 0% to 100%

*(Of 61 practices, 14 practices were excluded for no data or low numbers, therefore only 47 included in this analysis)

Table 5 shows a similar picture to NHS Health Checks, with fairly equitable success between the most and least deprived area for people who have successfully quit smoking at 6 weeks.

Table 4 Percentage of smokers setting quit date, successfully quitting

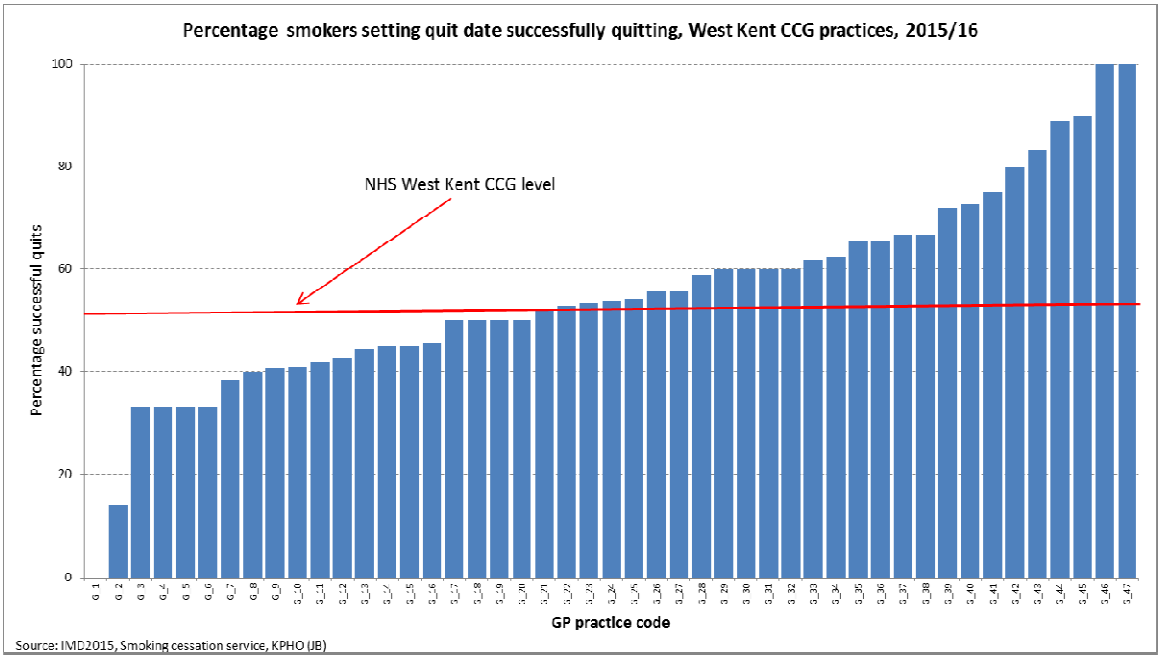
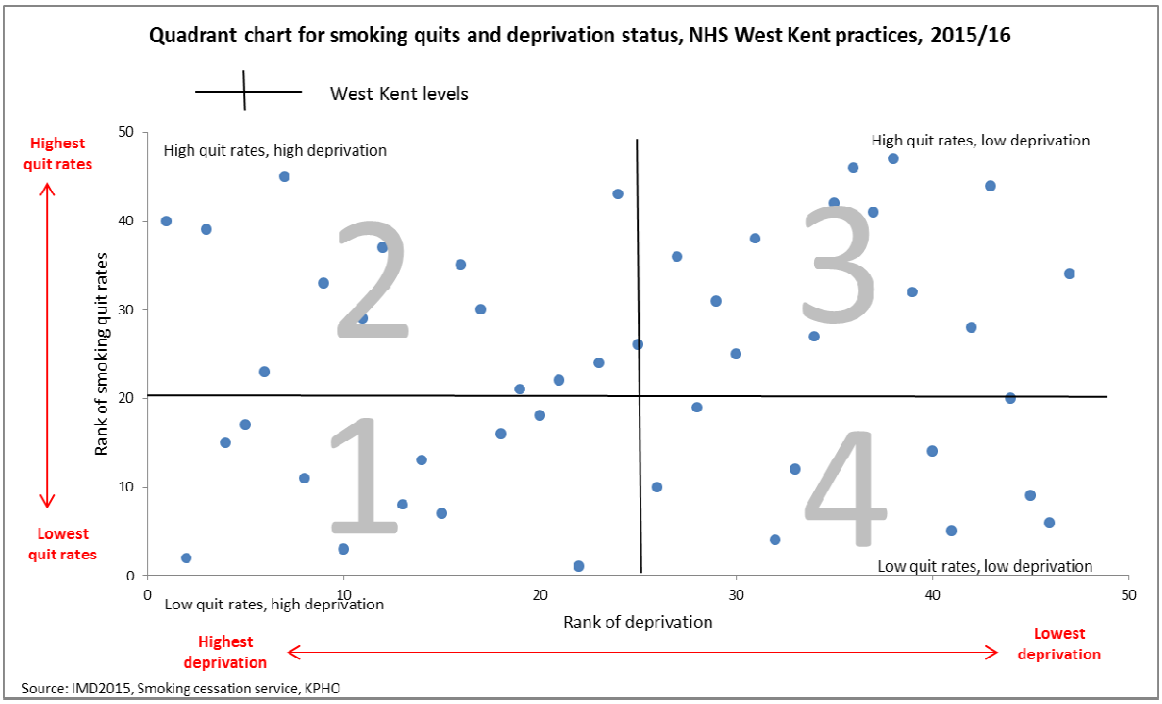


Table 5 Correlation between smoking quits and deprivation, West Kent CCG



Proposed approach

West Kent Health and Wellbeing Board have already delegated task and finish groups to undertake place based approach to addressing lifestyles, such as obesity and alcohol as outlined in the Kent Mind the Gap Action Plan. We need to move to a

systematic approach to disproportionately target the 28 identified poorest LSOA communities if we are to reduce the inequalities gap. This work has commenced in some districts, with community asset mapping taking place in the identified wards. The mapping will then lead to an understanding of the local area and if we are providing services, whether commissioned or voluntary, that meet local need.

Local areas are complex, holding a rich tapestry of visible and unknown individuals that combined, make up the community. Asset mapping is a systematic exercise that can assist in:[iv]

- Exploring the needs and fragility of local assets and understanding the conditions needed to help them flourish
- Knowledge and intelligence to effectively deploy resources to ensure that local organisations are supported in the right way to maintain and improve wellbeing
- Broaden knowledge of different organisations and entities that are playing a role in the local community

A 'community asset' could be anything within a local area that has a positive impact on people's lives, contributing to wellbeing in a variety of ways either intentionally or otherwise. Community asset mapping approach

1. Area selection and profiling (West Kent 28 LSOAs)
2. Asset identification
3. Asset profiling (ask key questions for meaningful understanding)
4. Resident insight

For discussion and consideration for adopting Asset Mapping approach

The Board is requested to agree and identify leadership to provide systematic, total place approach to disproportionately target the identified 28 poorest communities

Supporting Documents:

West Kent CCG Analysis of Deprived Areas (April 2016)

Asset Mapping and wellbeing Toolkit (Live it Well)

[i] UCL Institute of Health Equity. Fair Society, Healthy Lives: The Marmot Review - Strategic Review of Health Inequalities in England post-2010. 2010.
[ii] https://neighbourhood.statistics.gov.uk/HTMLDocs/nessgeography/superoutputareasexplained/output-areas-explained.htm
[iii] Mind the Gap: Health Inequalities Action Plan for Kent, 2016, KPHO
[iv] http://www.liveitwell.org.uk/wp-content/uploads/2015/12/Assett-mapping-guide.pdf

Maidstone

Background

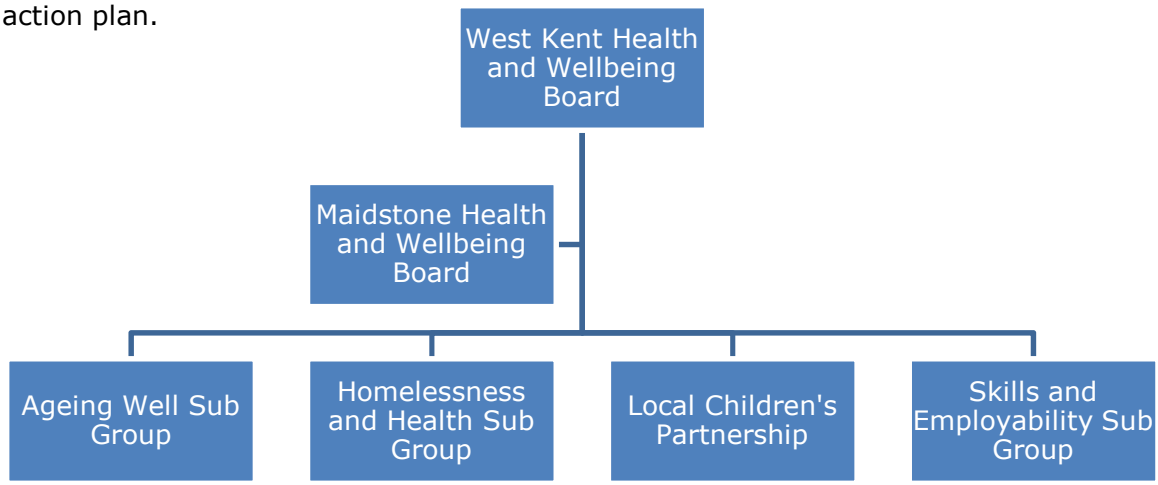
District Councils have a major role to play in public health. The functions we deliver such as planning, housing, economic development, environmental health, leisure and community safety have key impact on the health of communities.

In 2014, Maidstone Borough Council adopted its own Health Inequalities Action Plan outlining our commitment and actions for improving the health of populations within the borough. Our plan recognises that reducing health inequalities cannot be done in isolation; we depend on developing and sustaining partnerships with organisations in the borough to help us achieve the goals for our residents.

The action plan runs until 2020; however as data has development, knowledge has matured and local authorities face an ever-changing financial climate, a refresh was completed in October 2016 to review progress and ensure priorities are still relevant.

Structure

The Maidstone Health and Wellbeing Board have the responsibility to oversee the delivery of the health inequalities action plan and report progress back to the West Kent Health and Wellbeing Board. The group own the action plan, but are not the sole owners of the actions contained within in. There are 4 sub-groups supporting the delivery of the action plan.



The aim of each sub group is:

Ageing Well

- To work together as partners organisations and communities to improve local health outcomes for older people and build on the strengths of our diverse borough.

- To make prevention and early intervention the principles that guide how resources are deployed in Maidstone to achieve our priority outcomes.

Homelessness and Health

- To assess the impact of homelessness on the health of people in the borough
- To assess the initiatives currently in place to tackle homelessness and to address the health needs of homeless and vulnerable people in the borough
- To make effort to hear the views and opinions of some of the individuals concerned and make recommendations to the Council, the NHS and other relevant organisation to address the needs of rough sleepers and improve their health outcomes.

Local Children's Partnership

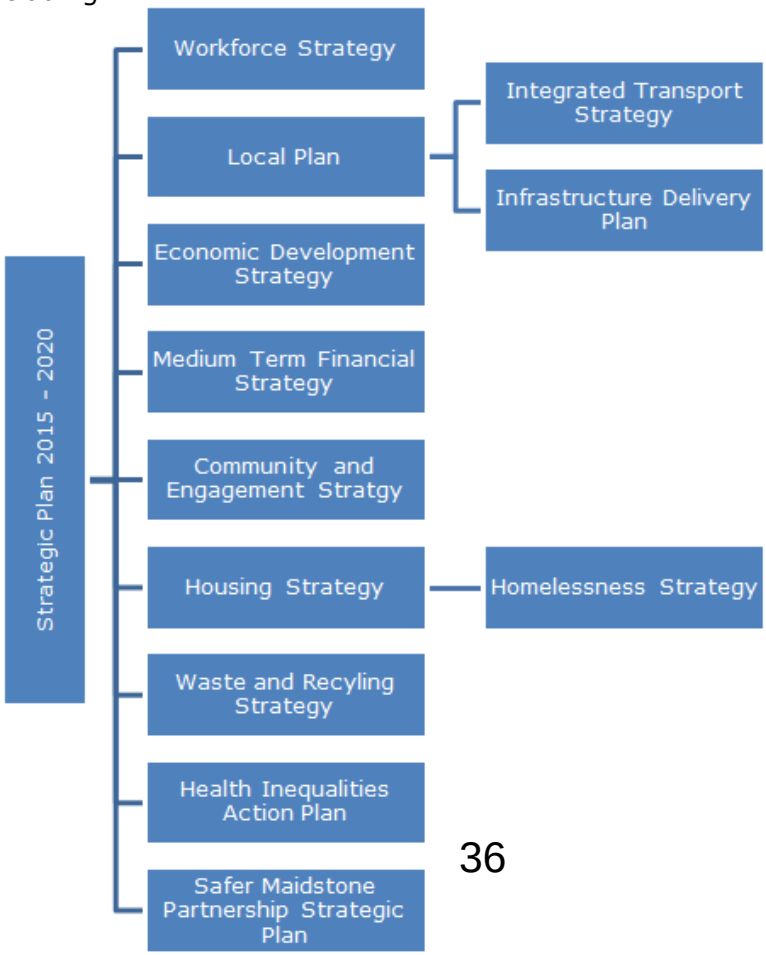
- Work in partnership at a district level and to drive improvement in specific outcomes for local children and young people.
- Sharing information to provide an understanding of local services and their thresholds.
- Providing a vehicle for identifying and addressing local needs and gaps in service provision.
- Facilitating and pooling resources to meet the needs of local children and families.

Skills and Employability

- To improve the employment prospects, education and skills of local people
- To support and promote growth in local economies and businesses to benefit local people.

The Marmot Priorities underpin the work of the subgroups by creating an enabling society that maximises individual and community potential; and to ensure social justice, health and sustainability.

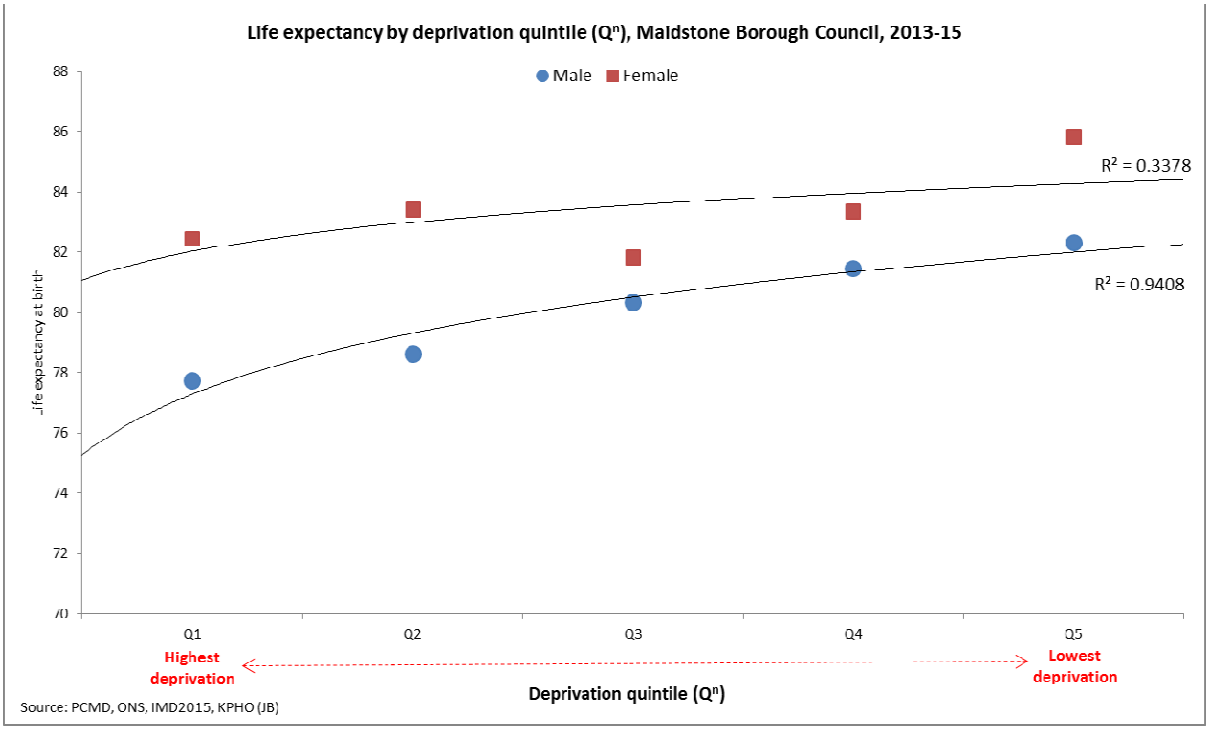
The Health Inequalities Action Plan is not the only plan which tackles health inequalities among our residents. A number of other key plans and strategies of Maidstone Borough Council contribute to improving the health and wellbeing and reducing the gap in inequality including:



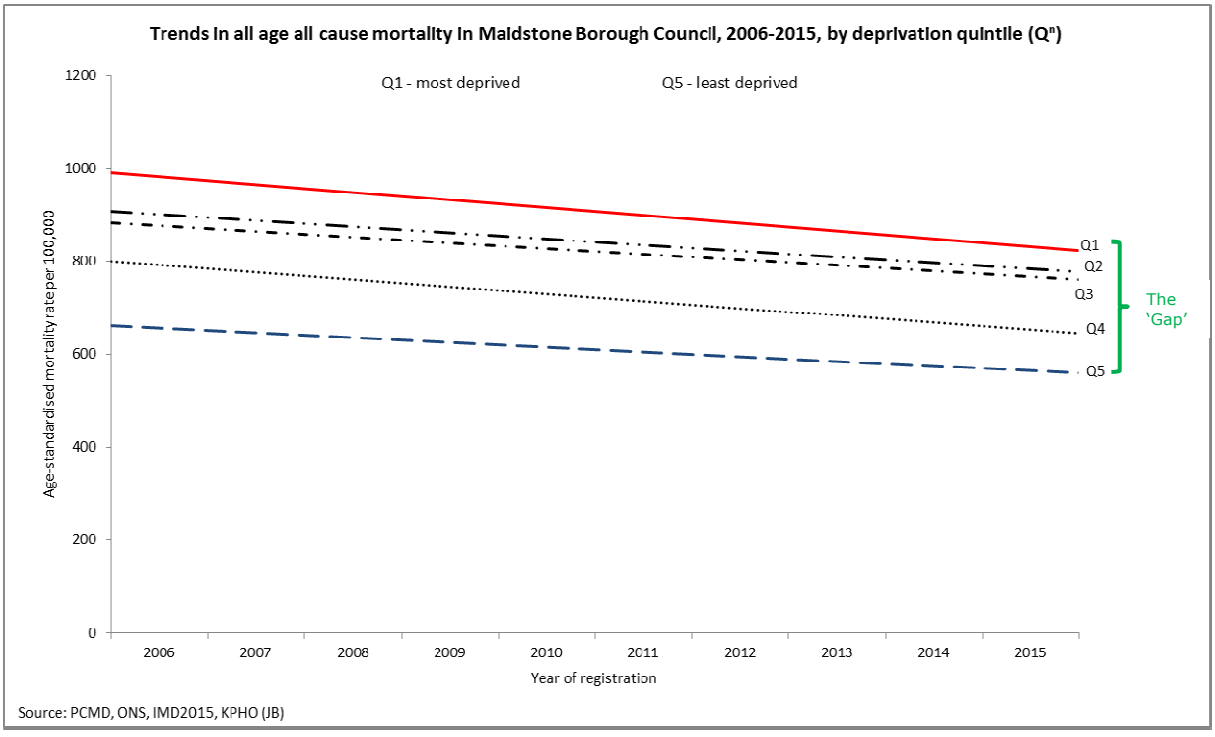
Measuring Health Inequalities

Overall indicator of progress in tackling health inequalities is to look at how mortality rates have changed over time for the most deprived compared to our least deprived.

It can be seen that although people's life expectancy is increasing, the gap in mortality rates between the most and least deprived remains largely unchanged.
The graph below looks at life expectancy by deprivation of those living in the bottom quintile and top quintile within the Maidstone Borough from 2013-2015. It shows that those living in the most deprived areas have a lower life expectancy than those living in the least deprived areas.



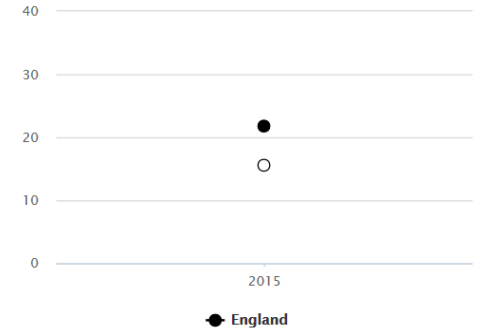
Although mortality rates have been falling over the past decade, the 'gap' in mortality rates between the most and least deprived persists (all lines are decreasing). The red line shows the most deprived population and the bottom line shows the least deprived population.



This persistent gap in health outcomes is not a phenomenon that is unique to Maidstone or Kent; the Office of National Statistics recently reported that there has been a persistent fixed gap in the life expectancy across England as a whole.[1]

In 2015, the deprivation score for Maidstone is 15.6 which is significantly lower than the deprivation score for England (21.8). This disguises pockets of deprivation at ward level and lower super output areas (LSOA)

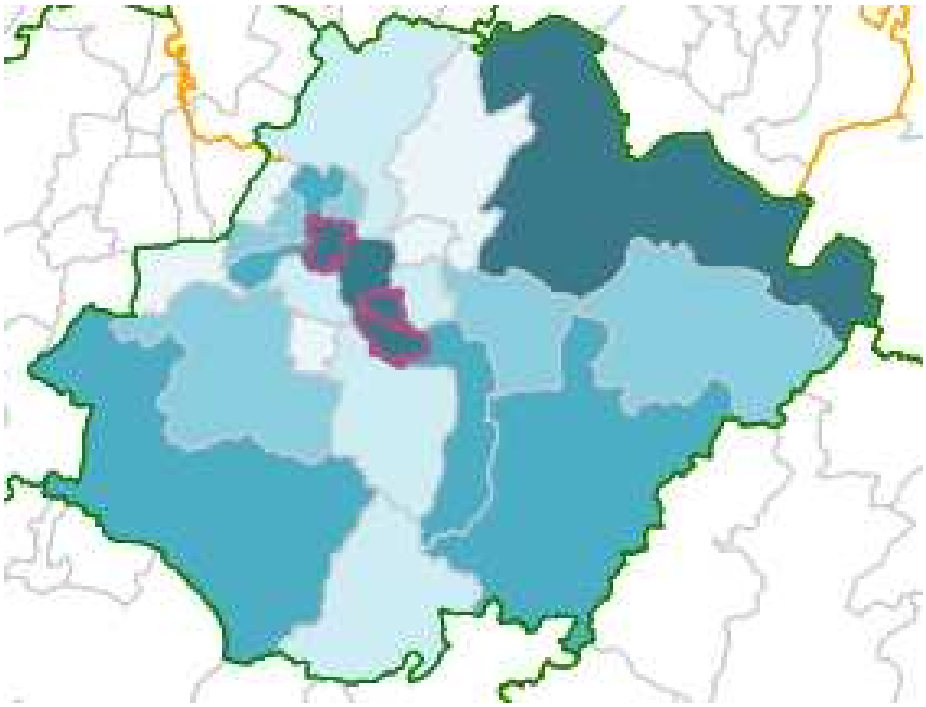
Deprivation score (IMD 2015) Maidstone



Period		Count	Value	Lower CI	Upper CI	South East	England
2015	○	-	15.6	-	-	-	21.8

Source: Department of Communities and Local Government (DCLG)

Within the Maidstone borough, Park Wood; Shepway South and High Street are identified as areas of deprivation. It is important to remember that other pockets of deprivation do exist across the borough.



[1] Office for National Statistics. Statistical Bulletin Health Expectancies at birth by Middle Layer Super Output Areas, England, Inequality in Health and Life Expectancies within Upper Tier Local Authorities: 2009 to 2013. 2015:1-22.

Progress

Actions listed within the Maidstone Health Inequalities Action Plan were time-bound to 2015 and 2020 to assist with monitoring. However, it is hard to develop trends over a short period of time and to see statistically significant difference, particularly when there is a change of data collection so no comparisons can be drawn.

Kent Public Health Observatory has mapped Maidstone's progress to date, June 2016.

The following indicators have been identified as significantly better than the national average:

- Child Poverty (% of children under 16 in low income families)
- GCSE Attainment (% achieving 5 good GCSEs A*-C including English and Maths)
- Households that experience fuel poverty (%) (low income, high cost methodology)

These areas are significantly worse than the national average:

- Statutory Homelessness Acceptances (per 1000 households)
- Admission episodes for alcohol-related conditions (ASR per 100,000)
- Excess winter deaths (single year, all ages/person)

Whereas, these are not significantly different than the national average:

- Excess weight in adults
- Killed and seriously injured on roads, crude rate per 100,000
- Emergency readmissions within 30 days of discharge from hospital

Health Inequalities Indicators for [District] 2016

The colour denotes whether the latest district value is better or worse than the national value or target value.
The trend line denotes the trend in the district over the recent history

District significantly better than national rate = Green
District significantly worse than national rate = Red
District not significantly different from national = Yellow

Lifecourse Stage	Indicator	Indicator Description	National (latest)	Kent (latest)	District (prior)	District (latest)	Performance Indicator	Latest Data Period
INFANCY	Infant Mortality	Infant mortality (rate per 1000 live births)	4.0	2.9	2.1	1.5	↓	2012-2014
	Smoking in Pregnancy	Smoking status at time of delivery (as % of maternities)	11.4%	12.60%	No data published	9.41		2014/15
	Breast Feeding	Breast feeding initiation (as % of maternities)	74.3%	71.30%	77.7%	75.8%	↓	2014/15
	Teen pregnancy	Under 18 Conceptions (rate per 1,000 females aged 15-17)	22.8	22.2	15.6	18	↑	2014
	Childhood Obesity (YR)	Excess weight in 4-5 year olds (% of children overweight or obese)	21.9%	22.5%	16.6%	20.6%	↑	2014/15
CHILDHOOD	Childhood Obesity (Y6)	Excess weight in 10-11 year (% of children overweight or obese)	33.2%	32.8%	31.4%	31.5%	↑	2014/15
	Childhood Poverty	Childhood Poverty (% of children under 16 in low income families)	18.6%	17.3%	14.0%	13.3%	↓	2013
	Education (attendance)	Pupil Absence (% half days missed due to unauthorised/authorised absence 5-15yr olds)	4.51%	4.70%	5.10%	4.4%	↓	2013/14
	Education (attainment)	GCSE Attainment (% achieving 5 good GCSEs A*-C including English and Maths)	56.8%	58.0%	70.8%	64.8%	↓	2013/14
	Childhood injuries	Hospital admission caused by injuries in children (aged 0-14 years) per 10,000 population	109.6	103.0	92.6	88.5	↓	2013/14
ADULTS	Unemployment	Longterm Unemployment (per 1000 of working age population)	7.1	5.6	5.5	3.3%	↓	2014
	Homelessness	Statutory Homelessness Acceptances (per 1000 households)	2.4	1.9	2.4	3.2	↑	2014/15
	Violent Crime	Violent crime (violence offences, crude rate per 1000 population)	13.5	15.6	14.2	15	↑	2014/15
	Healthy Eating	Proportion of population meeting the recommended '5-a day'	52.3%	56.2%	58.4%	56.9%	↓	2015
	Healthy Weight	Excess weight: excess weight in adults	64.6%	65.1%	-	65.5%		2012-2014
	Physical Activity	Physical Inactivity (<30mins per week of moderate activity)	27.7%	28.4%	25.2%	25.4%	↑	2014
	Smoking	Smoking prevalence in adults (%) (from integrated household survey)	18.0%	19.1%	14.5%	17.3%	↑	2014
	Alcohol	Admission episodes for alcohol-related conditions (Broad) (ASR per 100,000)	2120	1695	1589	1620	↑	2014/15
	Road Injuries	Killed and seriously injured on roads, crude rate per 100,000	39.3	39.6	38.6	40.6	↑	2012-14
ELDERLY	Fuel Poverty	Fuel Poverty - households that experience fuel poverty (%) (low income, high cost methodology)	10.4%	8.6%	7.9%	7.8%	↓	2013
	Winter Deaths	Excess winter deaths index (single year, all ages/persons)	11.6	13.8	31.2%	15.6%	↓	2013/14
	Falls	Injuries due to falls in people aged 65 and over (ASR per 100,000)	2125	2201	2415	2438	↑	2014/15
	Hip Fractures	Hip Fractures in people aged 65 and over (ASR per 100,000)	571	598	576	624	↑	2014/15
	Readmissions	Emergency readmissions within 30 days of discharge from hospital (Persons)	11.8	11.9	10.9	11.5%	↑	2011/12
	Cancer Screening (Breast)	Cancer Screening Coverage - Breast Cancer - % of eligible women screened in prior 3 years	75.4%	77.0%	79.6%	79.6%	↔	2015
	Cancer Screening (Cervical)	Cancer Screening Coverage - Cervical Cancer - % of eligible women screened in prior 3.5 or 5.5 years	73.5%	77.1%	78.6%	78.2%	↓	2015
	Cancer Screening (Bowel)	Cancer screening coverage - bowel cancer - % of eligible people screened in previous 2.5 years	57.1%	58.1%	-	62.7%		2015
	Place of Death	Percentage of deaths that occur in hospital	47.4%	41.7%	48.7%	46.1%	↓	2015
	Place of Death	Percentage of deaths that occur in Usual Place of Residence	44.7%	46.2%	45.9%	48.2%	↑	2015
MORTALITY	Premature Mortality	Premature mortality from all causes, under 75, (ASR per 100,000)	337.0	318.0	298	304	↑	2012-2014
	Premature Mortality (cardio)	Under 75 mortality rate from cardiovascular disease considered preventable (ASR per 100,000)	75.7	70.9	64.3	64.0	↓	2012-2014
	Premature Mortality (resp)	Under 75 mortality rate from respiratory disease considered preventable (ASR per 100,000)	32.6	30.9	31.1	30.3	↓	2012-2014
	Premature Mortality (cancer)	Under 75 mortality rate from cancer considered preventable (ASR per 100,000)	83	78.4	76.2	75.8	↓	2012-2014
	Premature Mortality (liver)	Under 75 mortality rate from liver disease considered preventable (ASR per 100,000)	15.7	13.7	10.7	14.2	↑	2012-2014
	Air-pollution-related Mortality	Fraction of mortality attributable to air pollution (PM2.5) (% of all age all cause mortality)	5.3%	5.4%	5.1%	5.5%	↑	2013
	Communicable Disease Mortality	Mortality from communicable disease (ASR per 100,000)	63.2	64.4	75.2	69.5%	↓	2010-2012
	Smoking-related Mortality	Smoking-related deaths (ASR pr 100,000)	279.0	266.7	-	256.1		2011-2013
	Alcohol-related Mortality	Alcohol-related mortality (ASR per 100,000)	45.5	42.4	46.0	41.9	↓	2014
	Suicide	Suicide age-standardised rate per 100,000 (3 year average)	8.9	10.2	8.7	10.1	↑	2012-14
	Preventable Mortality	Mortality rate from causes considered preventable	182.7	169.8	159.8	162.4	↑	2012-2014
	Life Expectancy (male)	Life expectancy at birth - years (male)	79.5	80.1	80.2	80.4	↑	2012-2014
	Life Expectancy (female)	Life expectancy at birth - years (female)	83.2	83.6	83.6	83.4	↓	2012-2014
	Life Expectancy Gap (males)	Slope index of inequality in life expectancy at birth based on local deprivation deciles - years (males)	9.2	7.4	5.4	5.6	↑	2012-2014
	Life Expectancy Gap (females)	Slope index of inequality in life expectancy at birth based on local deprivation deciles - years (females)	7.0	4.4	3.8	3.2	↓	2012-2014

Challenges

- District councils have no statutory responsibility for public health, the responsibility and commissioning lies with Kent County Council. However, if we choose not to act we forego the opportunity to influence the delivery of services that could reduce health inequalities in the borough.

- It is hard to demonstrate the cost benefits for interventions particularly those focused on wider determinants of health at a district level.

- The time lapse of data available makes it difficult to see if interventions/commissioning are effective.

- Health Inequalities is not a quick fix and breaking the cycle of health inequalities amongst communities is complex. How do you engage with the disengaged?

- The implementation of the Health Inequalities Action Plan and sustaining internal and external relationships with ever-changing financial climate, turnover of staff and priorities from Kent County Council.

Going forward

In continuing to deliver core public health services from existing revenues, the Council must seek new, pioneering ways of delivery to achieve more and produce better outcomes with fewer resources. Taking a strategic approach to public health across all services will help the Council to better align and target resources in line with health and wellbeing priorities.

1) Continue with the delivery of the Maidstone Health Inequalities Action Plan, strengthening partnerships to achieve results.

2) Support Kent County Council in the implementation and delivery of Mind the Gap 2016 which focuses on a community asset based approach in lower super output areas (Park Wood, Shepway, High Street ward). We are close with our communities to understand how they work and how to best reach and support them.

3) Continue to embed health within the culture of Maidstone Borough Council to deliver a whole systems approach in tackling health inequalities.

   Over the past few months, training has been delivered to Members and Heads of Services to identify how they can contribute further to improve health and wellbeing. Following the training, 'health champions' have come forward from each service area to champion public health across the council and innovate new ways of best practice across services and departments.

Appendices

Appendix A – 2015/16 Progress Report
Appendix B – Maidstone Health Inequalities Action Plan (Refresh 2016)

Appendix A: Maidstone Health Inequalities 2015/16 Progress Report

Information prepared by Maidstone Borough Council and supported by Kent County Council, Kent Public Health

Introduction

In 2012, Kent County Council launched Mind the Gap. Mind the Gap is Kent's Health Inequalities Action Plan which aims to improve health and wellbeing for everyone in Kent by narrowing the gap in health status between the most and least deprived communities. It provides a framework and tools to identify, analyse and evaluate actions that contribute to reducing health inequalities.

The Maidstone Health Inequalities Action Plan was developed following the transfer of public health responsibility to local authorities from the NHS. Tackling inequalities is a task that will require the efforts of all; across multiple organisations and within communities themselves. District Councils have a key role to play in keeping us healthy. We have a distinct, local role in service provision, economic development, planning, and helping to shape and support our communities – all key areas that are increasingly recognised as vital components of a true population health system.

There are 6 policy objectives embedded into the action plan based on the principles of the 'Fair Society, Healthy Lives' written by Professor Sir Michael Marmot.

- 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 a healthy standard of living
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

Health is impacted by wider determinants of health such as education, employment, housing, physical environment, relationships/networks; and these need to be addressed in order to improve health and wellbeing. Health services are not always the solution.

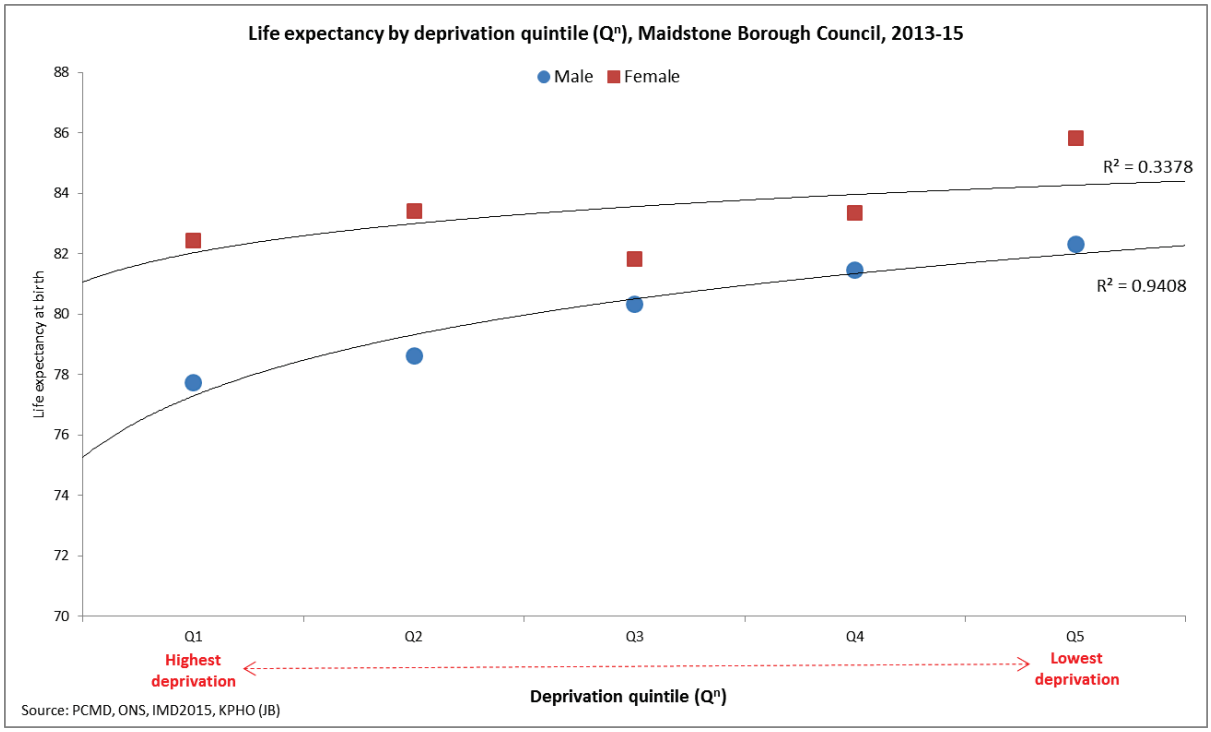
Now we are nearly two years in, it is an opportunity to review progress against actions and move forward in closing the gap in health inequalities.

Measuring Health Inequalities

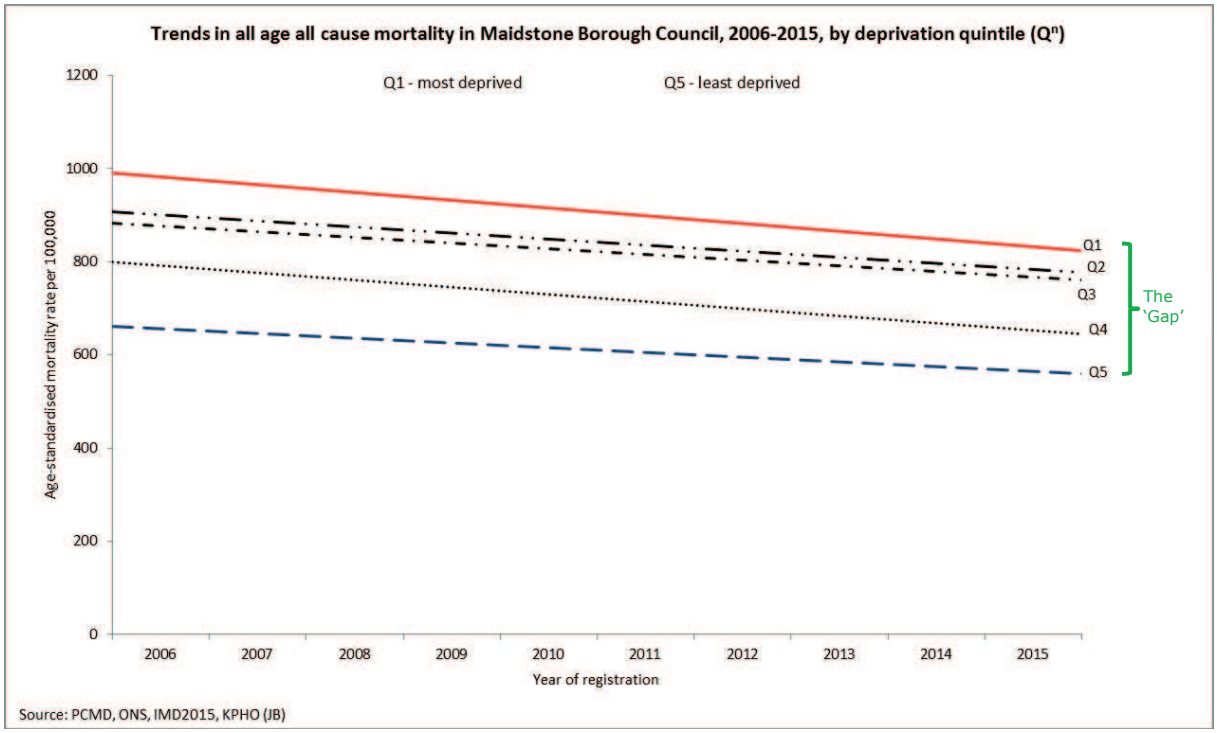
Overall indicator of progress in tackling health inequalities is to look at how mortality rates have changed over time for the most deprived compared to our least deprived.

It can be seen that although people's life expectancy is increasing, the gap in mortality rates between the most and least deprived remains largely unchanged.

The graph below looks at life expectancy by deprivation of those living in the bottom quintile and top quintile within the Maidstone Borough from 2013-2015. It shows that those living in the most deprived areas have a lower life expectancy than those living in the least deprived areas.



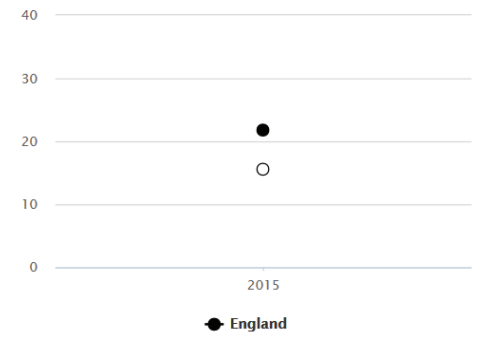
Although mortality rates have been falling over the past decade, the 'gap' in mortality rates between the most and least deprived persists (all lines are decreasing). The red line shows the most deprived population and the bottom line shows the least deprived population.



This persistent gap in health outcomes is not a phenomenon that is unique to Maidstone or Kent; the Office of National Statistics recently reported that there has been a persistent fixed gap in the life expectancy across England as a whole.[1]

In 2015, the deprivation score for Maidstone is 15.6 which is significantly lower than the deprivation score for England (21.8). This disguises pockets of deprivation at ward level and lower super output areas (LSOA)

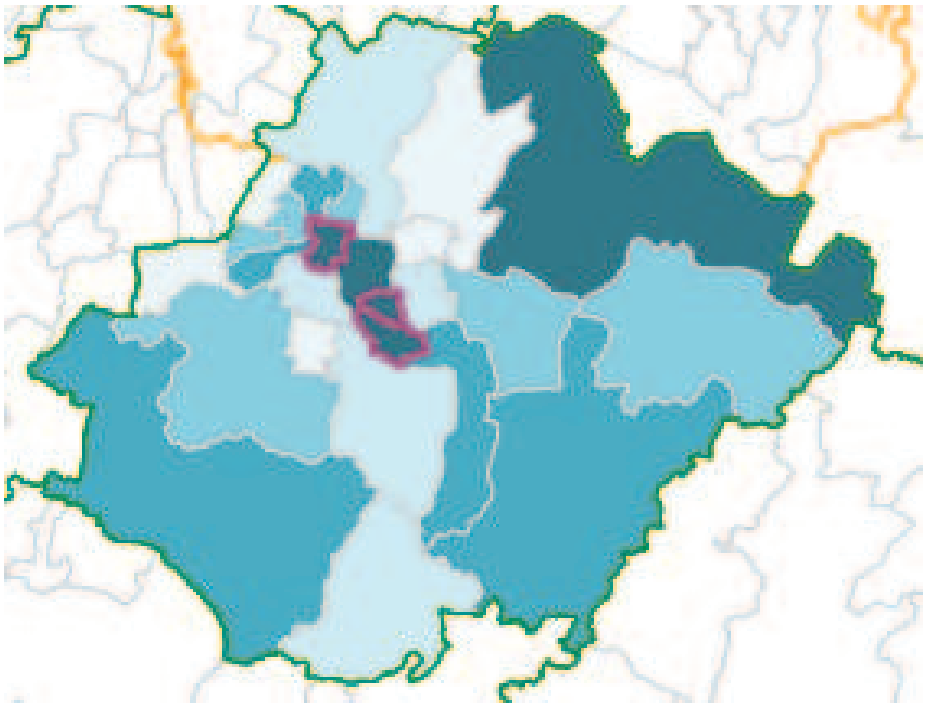
Deprivation score (IMD 2015) Maidstone



Period		Count	Value	Lower CI	Upper CI	South East	England
2015	○	-	15.6	-	-	-	21.8

Source: Department of Communities and Local Government (DCLG)

Within the Maidstone borough, Park Wood; Shepway South and High Street are identified as areas of deprivation. It is important to remember that other pockets of deprivation do exist across the borough.



[1] Office for National Statistics. Statistical Bulletin Health Expectancies at birth by Middle Layer Super Output Areas, England, Inequality in Health and Life Expectancies within Upper Tier Local Authorities: 2009 to 2013. 2015:1-22.

Indices of multiple deprivation 2015

Name	Ward values Index of mulitple deprivation (2015)
Allington	4.61
Barming	4.27
Bearsted	3.91
Boughton Monchelsea and Chart Sutton	10.25
Boxley	8.76
Bridge	10.51
Coxheath and Hunton	12.31
Detling and Thurnham	8.51
Downswood and Otham	9.96
East	13.17
Fant	17.88
Harrietsham and Lenham	12.74
Headcorn	14.7
Heath	13.03
High Street	27.83
Leeds	11.59
Loose	6.73
Marden and Yalding	18.33
North	17.18
North Downs	21.96
Leeds	11.59
Loose	6.73
Marden and Yalding	18.33
North	17.18
North Downs	21.96
Park Wood	33.3
Shepway North	23.99
Shepway South	34.54
South	9.98
Staplehurst	9.43
Sutton Valence and Langley	13.42

Progress to date

Actions listed within the Maidstone Health Inequalities Action Plan were time-bound to 2015 and 2020 to assist with monitoring. However, it is hard to develop trends over a short period of time and to see statistically significant difference, particularly when there is a change of data collection so no comparisons can be drawn.

Progress has been noted against each priority and provided as an overview of each action. It is important to note that information cannot necessary be drawn from the data alone.

Priority 1: Give every child the best start in life

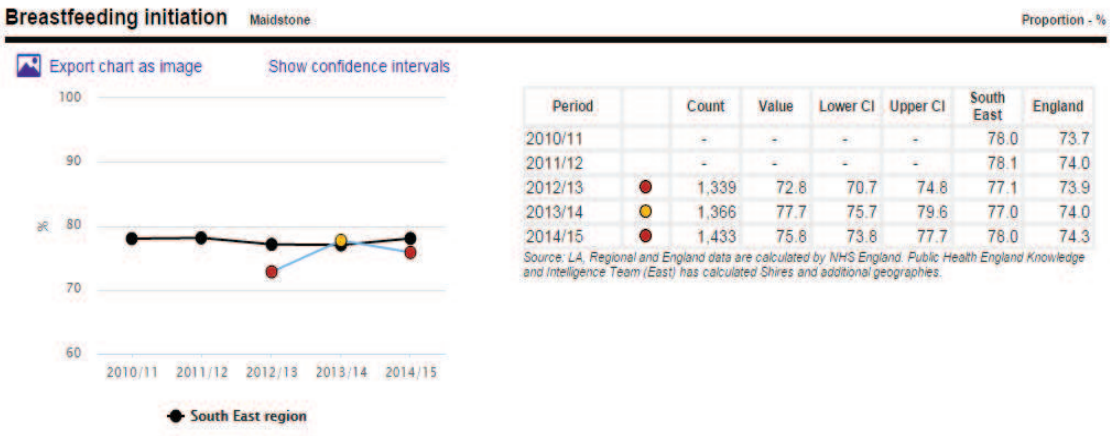
A child's early years lay down the foundation for the rest of their life, and the first three years are most crucial. This is a crucial period of physical, intellectual and emotional development.

Inequalities are introduced before birth, as the health of a child is greatly affected by the health of their mother during pregnancy. Maternal stress, diet, smoking, drug and alcohol use all influences a baby's development in the womb.

Breastfeeding
Breastfeeding contributes significantly to the long term health of both infants and mothers and increases maternal bonding.

Breastfeeding initiation in Maidstone is better than national and Kent figures but has been less significantly worse than the South East. The breastfeeding initiation rate in Maidstone for those mothers who breastfeed their babies in the first 45 hours after delivery has increased slightly from 74.6% to 75.8%.

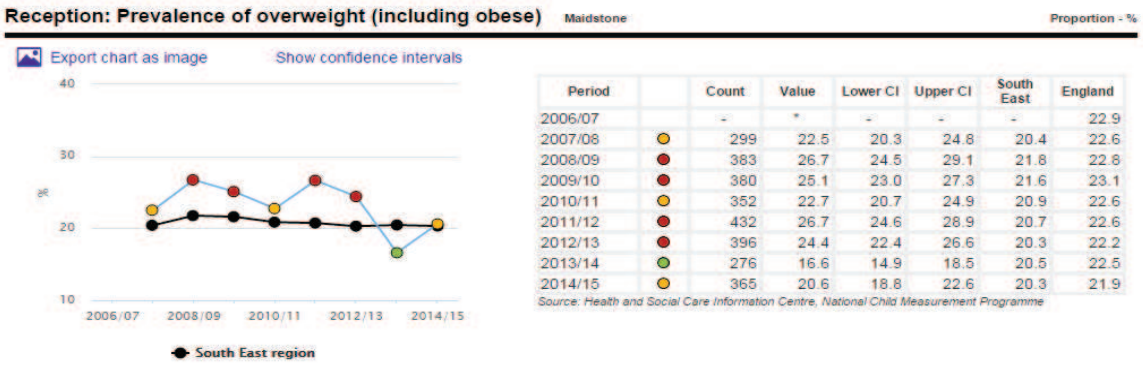
Data is insufficient to report on the prevalence of breastfeeding at 6-8 weeks.



Period		Count	Value	Lower CI	Upper CI	South East	England
2010/11		-	-	-	-	78.0	73.7
2011/12		-	-	-	-	78.1	74.0
2012/13		1,339	72.8	70.7	74.8	77.1	73.9
2013/14		1,366	77.7	75.7	79.6	77.0	74.0
2014/15		1,433	75.8	73.8	77.7	78.0	74.3

Source: LA, Regional and England data are calculated by NHS England. Public Health England Knowledge and Intelligence Team (East) has calculated Shires and additional geographies.

Excess Weight in Children
Although the prevalence rates in Maidstone for overweight children at Year R and Year 6 are similar to England and South East rates, childhood obesity remains a priority for Kent and for the West Kent Health and Wellbeing Board.



Period		Count	Value	Lower CI	Upper CI	South East	England
2006/07		-	*	-	-	-	22.9
2007/08		299	22.5	20.3	24.8	20.4	22.6
2008/09		383	26.7	24.5	29.1	21.8	22.8
2009/10		380	25.1	23.0	27.3	21.6	23.1
2010/11		352	22.7	20.7	24.9	20.9	22.6
2011/12		432	26.7	24.6	28.9	20.7	22.6
2012/13		396	24.4	22.4	26.6	20.3	22.2
2013/14		276	16.6	14.9	18.5	20.5	22.5
2014/15		365	20.6	18.8	22.6	20.3	21.9

Source: Health and Social Care Information Centre, National Child Measurement Programme

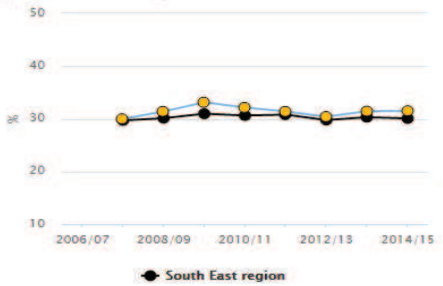
Compared with benchmark: Better Similar Worse

* a note is attached to the value, hover over to see more details

Trends for: Maidstone All in South East region

Year 6: Prevalence of overweight (including obese) Maidstone Proportion - %

Export chart as image Show confidence intervals



Period		Count	Value	Lower CI	Upper CI	South East	England
2006/07		-	*	-	-	-	31.7
2007/08		394	30.0	27.6	32.5	29.7	32.6
2008/09		464	31.4	29.1	33.8	30.1	32.6
2009/10		516	33.1	30.8	35.5	31.0	33.4
2010/11		495	32.1	29.9	34.5	30.6	33.4
2011/12		472	31.4	29.1	33.8	30.8	33.9
2012/13		449	30.4	28.1	32.8	29.8	33.3
2013/14		486	31.4	29.2	33.8	30.3	33.5
2014/15		483	31.5	29.2	33.9	30.1	33.2

Source: Health and Social Care Information Centre, National Child Measurement Programme

Data from the National Child Measurement Programme shows a reduction in the number of obese children in reception year (10.7% down to 8.2%) and year 6 (20.0% down to 14.9%). However it is important to note that new cohorts of children are measured each year. Experiences in childhood affect behaviours and habits into adulthood.

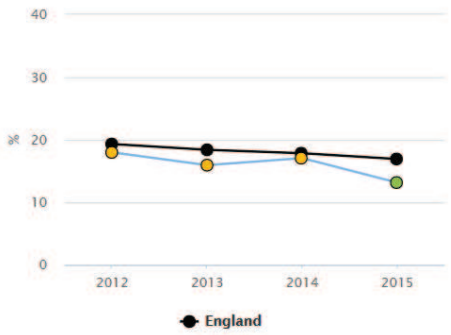
Priority 2: Enable all children, young people and adults to maximise their capabilities and have control over their lives

As children develop into young adults, they go through physical, emotional and psychological changes as they establish their own identities, independent from their families and carers. This is a time when services can offer children and young people opportunities to improve and shape their lives for the better, with impacts which last long into adult life.

Teenage Conceptions
The Under 18 conception rate in Maidstone is similar to the rate in England the South East and is declining. However, this disguises higher rates in Park Wood, Shepway South and High Street.

Smoking
In 2015, Maidstone has seen an improvement from the South East and National average with only 13.2% of the population smoking.

Smoking Prevalence in adults Maidstone — Proportion - %



Period		Count	Value	Lower CI	Upper CI	South East	England
2012		-	18.0	13.5	22.5	17.9	19.3
2013		-	15.9	11.6	20.3	17.2	18.4
2014		-	17.1	12.6	21.6	16.5	17.8
2015		-	13.2	9.4	16.9	15.9	16.9

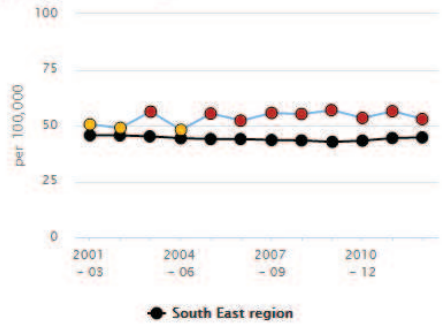
Source: Annual Population Survey (APS)

However, smoking attributable mortality in Maidstone is similar to the England and the South East region; deaths from Chronic Obstructive Pulmonary Disease

(COPD) are significantly higher. This is also reflected in a higher rate of Emergency admissions for COPD.

Deaths from chronic obstructive pulmonary disease Maidstone — Directly standardised rate - per 100,000

Export chart as image | Show confidence intervals



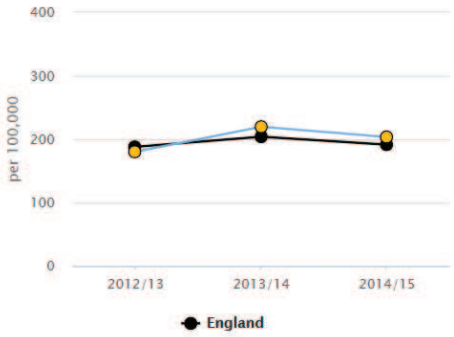
Period		Count	Value	Lower CI	Upper CI	South East	England
2001 - 03		173	50.4	43.2	58.6	45.6	55.7
2002 - 04		169	48.9	41.8	57.0	45.6	54.9
2003 - 05		194	56.2	48.5	64.7	45.1	54.3
2004 - 06		171	48.1	41.1	55.9	44.3	52.1
2005 - 07		201	55.3	47.9	63.6	43.9	51.8
2006 - 08		198	52.2	45.1	60.1	43.9	51.6
2007 - 09		218	55.6	48.4	63.6	43.5	50.8
2008 - 10		223	55.1	48.1	62.9	43.3	50.1
2009 - 11		231	56.9	49.7	64.7	42.7	49.1
2010 - 12		220	53.4	46.5	60.9	43.2	50.1
2011 - 13		240	56.4	49.4	64.0	44.4	51.5
2012 - 14		233	52.9	46.3	60.1	44.6	51.7

Source: Public Health England (based on ONS source data)

Hospital Stays for Self-Harm

Maidstone is not significantly different to the England average for hospital stays for self-harm, however a slight reduction has been noted from 215.3/100,000 to 205.67/100,000 (2014/15 data)

Hospital stays for self-harm Maidstone — Directly standardised rate - per 100,000



Period		Count	Value	Lower CI	Upper CI	South East	England
2012/13		283	180.2	159.8	202.5	183.0	188.0
2013/14		344	219.6	196.8	244.3	205.6	204.0
2014/15		324	203.4	181.8	226.9	193.1	191.4

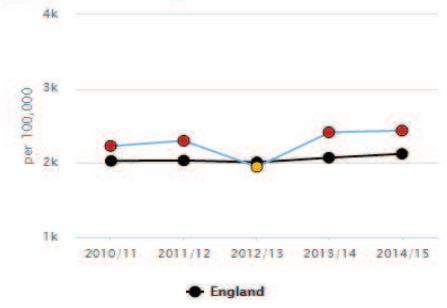
Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

Falls Prevention

The rate of injuries due to falls in the over 65s is higher in Maidstone than the England and South East. The rate of falls is significantly higher in over 85 year old men and women, although similar to those aged 65 to 74.

2.24i - Injuries due to falls in people aged 65 and over (Persons) Maidstone — Directly standardised rate - per 100,000

Export chart as image | Show confidence intervals



Period		Count	Value	Lower CI	Upper CI	South East	England
2010/11		615	2,230	2,048	2,422	1,994	2,030
2011/12		656	2,300	2,118	2,493	1,982	2,035
2012/13		573	1,949	1,785	2,123	1,962	2,011
2013/14		713	2,415	2,231	2,609	2,056	2,072
2014/15		741	2,438	2,257	2,629	2,086	2,125

Source: Calculated by West Midlands Knowledge and Intelligence Team from data from the Information Centre for Health and Social Care - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates

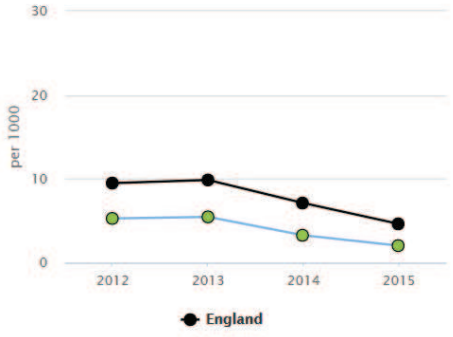
Priority 3: Create fair employment and good work for all

Patterns of employment both reflect and reinforce the social gradient, and being in good employment is protective of health. Unemployment leads to financial insecurity, psychologic stress, anxiety, depression and unhealthy behaviours such as smoking and alcohol consumption.

The quality of work is also important. Jobs that are insecure, low-paid and fail to protect employees from stress and physical danger lead to poorer health.

Unemployment
In Kent, the unemployment rate has been reducing over the last few years in all districts as the nation's economic recovery continues. The long-term unemployment rate in Maidstone is better than the England average.

Long term unemployment Maidstone — Crude rate - per 1000



Period		Count	Value	Lower CI	Upper CI	South East	England
2012		522	5.3	4.8	5.8	5.5	9.5
2013		540	5.5	5.0	5.9	5.5	9.9
2014		329	3.3	2.9	3.6	3.6	7.1
2015		205	2.0	1.8	2.3	2.3	4.6

Source: www.nomisweb.co.uk

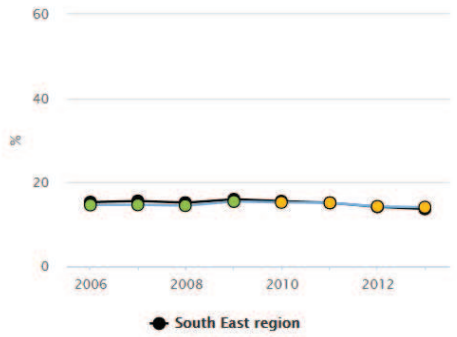
Businesses and workplaces have a key role to play in support good health and reducing health inequalities. Supervisor and peer support, stable rotas, safe conditions, an opportunity for training and promotion, and greater autonomy in the workplace are all factors that increase employees' wellbeing. In Maidstone, we work alongside Kent County Council to deliver the Kent Healthy Business Awards. The awards are self-assessed standard to help improve the health of the workforce. In 2014/15, 10 businesses had signed up to the awards in Maidstone, increasing to 31 businesses in 2015/16 with 5 achieving the awards.

Priority 4: Ensure a healthy standard of living for all

Income is a key determinant of health. Insufficient income is associated with worse outcomes in long term health and life expectancy. Income alone does not give a full picture of living standards.

Children in low income families (under 16s)
Maidstone is not significantly different to the region average for the number of children living in low income families; 14.1% in Maidstone compared to 13.7% South East region.

Children in low income families (under 16s) Maidstone — Proportion - %



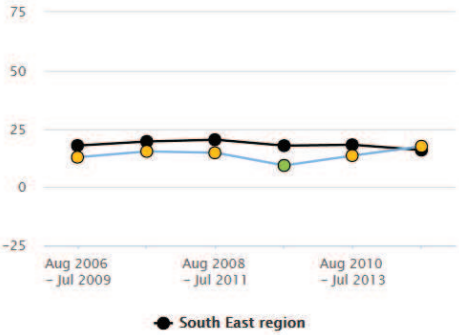
Period		Count	Value	Lower CI	Upper CI	South East	England
2006		3,995	14.6	14.2	15.0	15.3	21.8
2007		4,035	14.7	14.3	15.1	15.6	22.4
2008		3,985	14.5	14.1	14.9	15.2	21.6
2009		4,285	15.5	15.0	15.9	16.0	21.9
2010		4,250	15.2	14.8	15.7	15.5	21.1
2011		4,295	15.1	14.7	15.6	15.1	20.6
2012		4,120	14.3	13.9	14.7	14.2	19.2
2013		4,100	14.1	13.7	14.5	13.7	18.6

Source: HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics)

Fuel Poverty
The people most likely to die or become ill during the cold weather are those least about to afford to heat their homes. 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. The fuel poverty rate in Kent was 8.6% in 2013, less than the national rate of 10.4%. The number of excess winter deaths in Maidstone is not significantly different to the Kent average. Latest data available has Kent at 11.6% and Maidstone at 15.6%.

Please note the excess winter death trends seen below are only available to July 2013.

Excess winter deaths Maidstone — Ratio

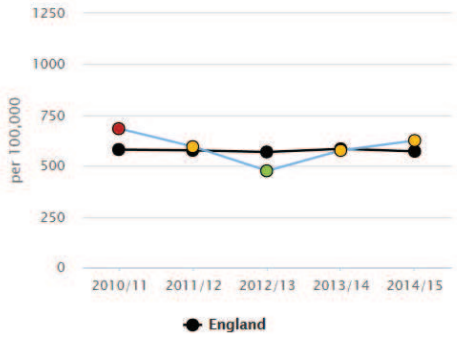


Period		Count	Value	Lower CI	Upper CI	South East	England
Aug 2006 - Jul 2009		161	12.8	5.7	20.4	17.8	18.1
Aug 2007 - Jul 2010		196	15.3	8.2	23.0	19.6	18.7
Aug 2008 - Jul 2011		191	14.7	7.6	22.3	20.3	19.0
Aug 2009 - Jul 2012		123	9.3	2.5	16.6	17.8	16.4
Aug 2010 - Jul 2013		177	13.5	6.5	21.0	18.2	17.4
Aug 2011 - Jul 2014		229	17.5	10.3	25.1	15.9	15.6

Source: Office for National Statistics: Public Health England Annual Births and Mortality Extracts

Hip fractures in people aged 65 and over Maidstone

Directly standardised rate - per 100,000



Period		Count	Value	Lower CI	Upper CI	South East	England
2010/11		185	683	582	795	582	580
2011/12		177	594	506	693	573	576
2012/13		144	475	398	562	554	568
2013/14		174	576	489	673	587	583
2014/15		191	624	535	724	560	571

Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2014, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

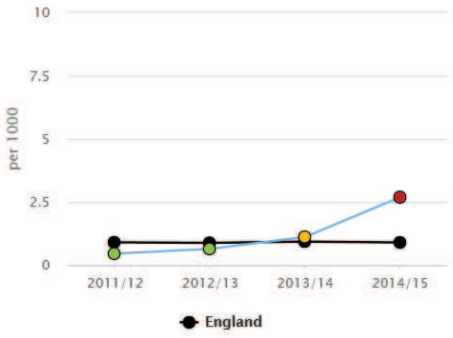
Priority 5: Create and develop healthy and sustainable places and communities

Creating a physical environment in which people can lead healthier lives is crucial to tackling health inequalities. Green spaces such as parks, woodland and other open spaces are associated with a number of health outcomes, relating to physical health, mental health and general wellbeing. There are many indirect benefits too, for example, providing space for social activity, sports and recreation and improving air quality.

Housing is a key aspect of inequalities; poor quality housing is a risk to health, and rates of overcrowded accommodation and shared dwellings are strongly associated with levels of deprivation.

Statutory homelessness
Homelessness can be more hidden in the form of temporary accommodation. This transient living can lead to poor continuity of care and service provision. In Maidstone, Statutory homelessness is persistently reported as red in Maidstone (significantly higher than the England average). The measure is the count of households who are eligible, unintentionally homeless and in priority need, for which the local authority accepts responsibility for securing accommodation under part VII of the Housing Act 1996 or part III of the Housing Active 1985. This comes from a return provided by housing authorities to the Department for Communities and Local Government (DCLG).

Statutory homelessness Maidstone — Crude rate - per 1000

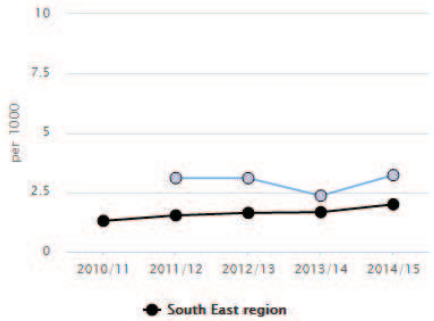


Period		Count	Value	Lower CI	Upper CI	South East	England
2011/12		28	0.5	0.3	0.7	0.5	0.9
2012/13		42	0.6	0.5	0.9	0.5	0.9
2013/14		73	1.1	0.9	1.4	0.7	0.9
2014/15		178	2.7	2.3	3.1	0.8	0.9

Source: Department for Communities and Local Government

1.15i - Statutory homelessness - homelessness acceptances Maidstone — Crude rate - per 1000

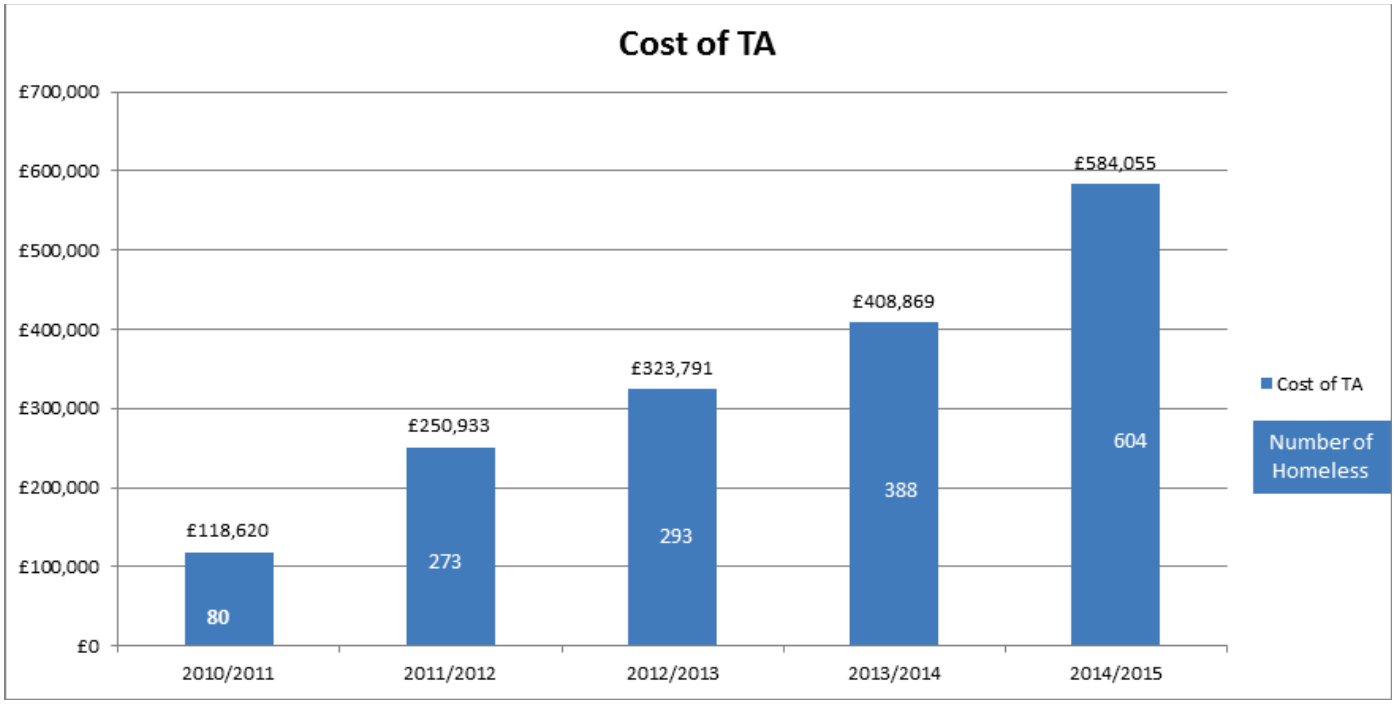
Export chart as image Show confidence intervals



Period		Count	Value	Lower CI	Upper CI	South East	England
2010/11		-	-	-	-	1.3	2.0
2011/12		189	3.1	2.7	3.6	1.5	2.3
2012/13		198	3.1	2.7	3.6	1.6	2.4
2013/14		155	2.4	2.0	2.8	1.7	2.3
2014/15		213	3.2	2.8	3.7	2.0	2.4

Source: Department for Communities and Local Government

In Maidstone, between April and June of 2016, 176 households have met the threshold to make a homelessness application. 149 decisions were made. In the same quarter in 2015/16 there were 150 applications and 132 decisions made.



(Approximately a 1/3 of those presenting as homeless are placed in temporary accommodation)

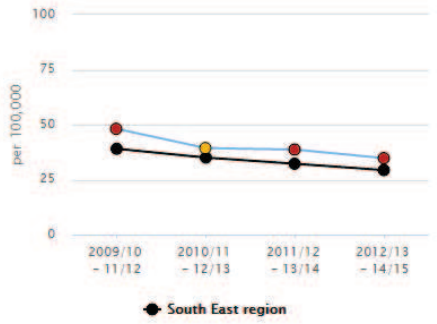
The length of stay in temporary accommodations has been reduced to 39.67 (2015/16); achieving the 2015 target of 42 days.

Violent Crime

Maidstone has significantly higher rates of violent crime than the South East average, higher than the national rate but lower than the Kent figure. It has risen from 12/13 to 14/15. The rate for violent crimes per 1000 is also higher in Maidstone than the South East. The rate of sexual violence per 1000 is not.

Misc: Violent crime (including sexual violence) - hospital admissions for violence Maidstone Directly standardised rate - per 100,000

Export chart as image Show confidence intervals



Period		Count	Value	Lower CI	Upper CI	South East	England
2009/10 - 11/12		224	48.1	42.0	54.9	39.0	62.8
2010/11 - 12/13		183	39.3	33.8	45.5	35.0	57.6
2011/12 - 13/14		179	38.7	33.2	44.8	32.2	52.4
2012/13 - 14/15		163	34.8	29.6	40.5	29.3	47.5

Source: Data supplied by Hospital Episode Statistics, Health and Social Care Information Centre (HSCIC). Values calculated by KIT(NW).

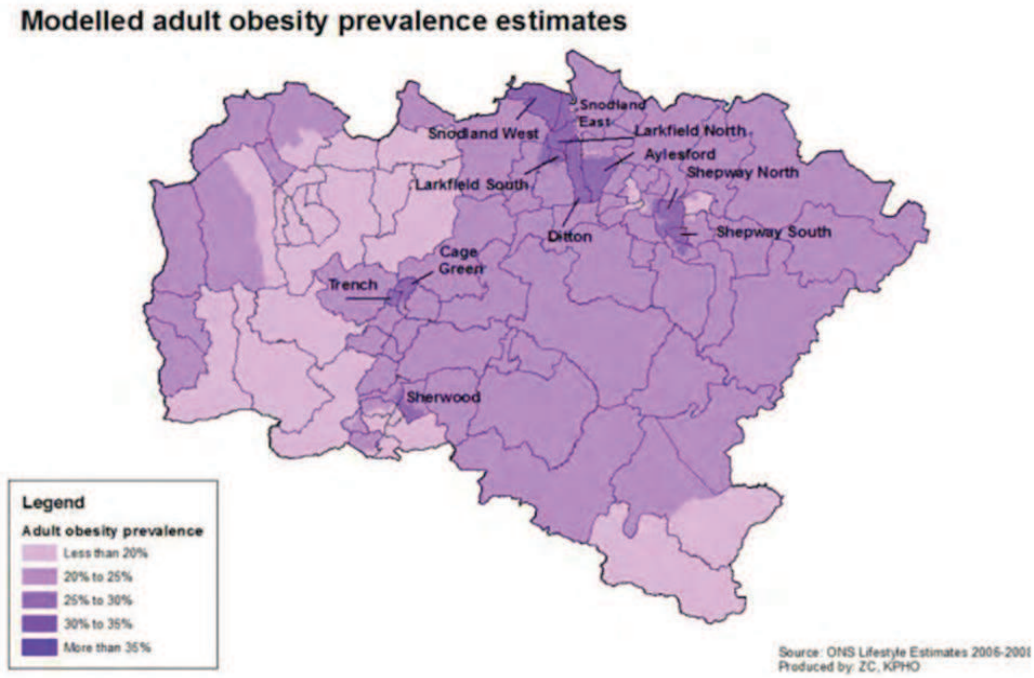
Priority 6: Strengthen ill-health prevention

Strengthening ill-health prevention also required improve partnership working amongst the public, private and voluntary sector to find new ways to target and deliver services particularly with those who are hard to reach.

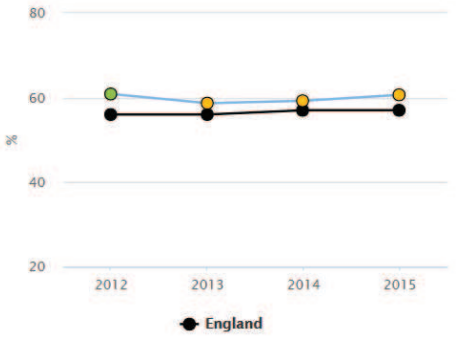
Maidstone Borough Council staff have been trained in Making Every Contact Count (MECC) as an approach to behaviour chance that utilises day-to-day interactions with our clients to support them in making positive changes to their physical and mental health and wellbeing.

Adult Obesity
Obesity/excess weight in adults data has changed over time, from 2006-2013 it was a % modelled estimated derived from the Health Survey of England using 2006-2008 data. From 2014, excess weight in adults was measured using Active People Survey 2014. Latest data shows 65.5% of Maidstone residents (aged 16 and over) have a BMI greater than or equal to 25kg/m².

The modelled data goes down to ward level to provide an indication of the relative prevalence. Shepway North, Shepway South and Park Wood are estimated to have 25% more prevalence of adult obesity.



Percentage of physically active adults Maidstone — Proportion - %



Period		Count	Value	Lower CI	Upper CI	South East	England
2012		-	60.9	56.5	65.3	58.7	56.0
2013		-	58.7	54.4	63.0	58.4	56.0
2014		-	59.3	55.0	63.5	59.0	57.0
2015		-	60.7	56.5	64.9	60.2	57.0

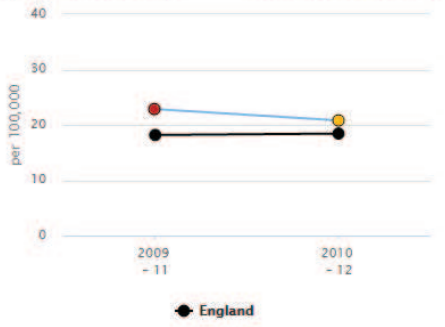
Source: Active People Survey, Sport England

Malignant Melanoma

Malignant Melanoma is not significantly different to the England average. The risk factors associated with malignant melanoma including being white, the high number of sunlight hours and being over 65 years old. This in itself may be why the South East is generally higher than the England average.

Incidence of malignant melanoma Maidstone — Directly standardised rate - per 100,000

Export chart as image Show confidence intervals



Period		Count	Value	Lower CI	Upper CI	South East	England
2009 - 11		93	22.9	18.4	28.0	21.1	18.2
2010 - 12		86	20.8	16.6	25.7	21.7	18.4

Source: Health and Social Care Information Centre

NHS Health Checks

The NHS Health Check programme is a national cardiovascular screening programme for all individuals aged 40-74 who are not already treated for cardiovascular disease. Since cardiovascular disease will affect many people as they age getting five-yearly check of blood pressure, weight and cholesterol is a way of identifying risks and getting advice and support to change lifestyles for the better.

The number of NHS Health Checks carried out within the borough exceeded our target of 1,500 to 2,908 (93.86% above target)

Indicators for Health Inequalities Action Plan

Actions identified within the Maidstone Health Inequalities Action Plan were time bound to 2015-2020. Kent Public Health Observatory has mapped Maidstone's progress to date, although this data cannot be used as standalone data due to inconsistency of data collected and reported.

Care needs to be taken in interpreting population health indicators and the changes that may have occurred in data may arrive as not statistically different.

The action plan is a partnership plan and not the sole responsibility of Maidstone Borough Council. Tackling health inequalities requires a co-ordinated approach.

Indicators for Maidstone Health Inequalities Action Plan 2014-2020

Priority	Target description	baseline	target	inc/ red	Review Date	Latest data available	Notes/Source
1a. Give every child the best start in life (conception to 9 months)	Reduce number of low birth weight babies	5.80%	4.80%	-1%	2015	6.10% (2012-14)	ONS via HSCIC
	Increase breast feeding initiation rates	74.60%	76.60%	+2%	2015	75.8% (2014/15)	% who breastfeed their babies in the first 45hrs after delivery (PHOF)
	Increase rate of breast feeding at 6-8 weeks	41.50%	43.50%	+2%	2015	Not available	Value has not been published for data quality reasons (PHOF)
	Reduce infant mortality rate	2.7/1,000	<3.1/1,000	n/a		2.0	Rate of deaths in infants aged under 1 year per 1,000 live births (PHOF)
	Reduce number of pregnant women smoking during pregnancy	12.20%	6%	-50%	2020	129 (Q3, 2015/16)	HSCIC. When Q3 maternities' are released this can be given as a percentage
1b. Give every child the best start in life 9 months +)	Reduce the number of obese children: reception year	10.70%	9.70%	-1%	2015	8.2% (2014/15)	National Child Measurement Programme
	Reduce the number of obese children: year 6	20.00%	19.00%	-1%	2015	14.9% (2014/15)	National Child Measurement Programme
	Increase % of children immunised before their 5 birthday	91.40%	95%	+3.6%		MMR2 85.3%, DTaP/IPV Booster 81.4% (2015/16)	Averages have been taken for quarters 1 and 2 2015/16
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives	Reduce hospital admissions for self harm	215.3/ 100,000	207.9	-3%	2020	205.67/100,000 (2014/15)	Admissions using 'X600' and X849' or 'Y100' and 'Y349' ICD 10 coding (SUS)
	Reduce number of teenage conceptions	34.3	<40/1,000	reduce	2020	18.0 (2014)	ONS
	Reduction in increasing and higher risk drinking	23.9	22.30%	-2%	2020	20.9% (IRD) and 6.8% (HRD) (2014)	[illegible] drinkers only) synthetic estimate' and 'higher risk drinking (HRD) (% of drinkers only) synthetic estimate'
	reduction in number hip fractures in over 65s	468	457	-2%	2020		
	Reduction in excess winter deaths	14.8	monitor	reduce	2020		
3. Create fair employment and good work for all	Reduce the number of 16-18 year olds NEET	6.00%	5%	-1%	2020		
	Reduce the number of 18-24 who are unemployed	765	monitor	reduce	2015	Kent 3,280 Maidstone makes up 2.4% - 787	
	Reduce the percentage of people claiming job seekers allowance	2.60%	2.60%	reduce			
	Increase the number of healthy workplaces	20	baseline	increase	2015	21 (2015 (to date))	MBC
4. Ensure a healthy standard of living for all	Reduce deprivation in key areas	7.20%	monitor	reduce	2020	7.5 (2015)	The % of people living in the 20% most deprived areas in England, 2015 (IMD 2015)
	Reduce the proportion of children living in poverty	15.20%	monitor	reduce	2020	0.15 (2015)	IDACI 2015
	Reduce inequality in life expectancy in the borough (male)	7	monitor	reduce	2020	11.7 (2011-15)	Figure given is the different between the highest life expectancy at ward level and the lowest life expectancy at ward level. Total life expectancy is 80.3 years (PCMD, ONS, SEPHO)
	Reduce inequality in life expectancy in the borough (female)	4.4	monitor	reduce	2020	16.2 (2011-15)	Figure given is the different between the highest life expectancy at ward level and the lowest life expectancy at ward level. Total life expectancy is 83.6 years (PCMD, ONS, SEPHO)
	Reduce number of households living in fuel poverty (10% of income)	12.70%	monitor	reduce	2020		
	Increase number of households supported to improve their energy efficiency	baseline	monitor	increase	2015		
5. Create and develop healthy and sustainable places & communities	Increase number of homeless preventions	592	450	+24%	2015		Not currently achievable due to the increase of households presenting as homeless
	Reduce number of households living in temporary accommodation	29	15	-1%	2015		Number of households in temporary accommodation has increased - target is not achievable
	Reduce recorded crime per 1,000 population	63.6	63.6	maintain	2015		
	Reduce levels of violent crime	11.5	monitor	reduce	2015		
	Percentage CO2 reduction from local authority operations	5481	5316	-3%			
	Reduce length of stay in temporary accommodation to 42 days	56 days	42 days	-25%	2015	39.67	
6. Strengthen the role and impact of ill health prevention	Increase the number of health checks delivered	1500	1500	maintain	2015	2,908 (2015/16)	The number of health checks completed for 2015/16 (to date) by GP's; aggregated to district level (KCHFT)
	Reduce the number of obese children: reception year	10.70%	9.70%	-1%	2015	Repeat of target (part of 1b)	
	Reduce the number of obese children: year 6	20.00%	19.00%	-1%	2015	Repeat of target (part of 1b)	
	Reduce adult obesity	26.30%	24.20%	-2%	2020	18.9% (2012)	Active People Survey 2012, part of Health Profiles 2015
	reduce the incidence of malignant melanoma	19.40	14.5	-5%	2020	21.7 (2010-12)	PHE Health Profiles
	Reduce the number of hospital stays for self harm	215.30	207.9	-3%	2020	Repeat of target (part of 2)	

Health Inequality Indicators for Maidstone – June 2016

Taking into account our current Health Inequalities Action Plan and the need to understand what data is available; Public Health England have a list of indictors which have been considered and organised across the life course, consistent with the national strategy for tackling health inequalities. Indicators have been selected based on:

- Each indicator must relate to health inequalities (e.g. social determinants of health, health behaviours, health service uptake/use, health outcomes)
- Indicators collectively cover a wide breadth of issues, but minimising overlap
- Data for each indicators must be collected in a robust way, and consistent methodology, at least at County level, and ideally at District level (indicated where this is the case)
- Must be accessible on Public Health England (PHE) Fingertips website, for ease of access: fingertips.phe.org.uk/
- Data for each indicator must have been collected recently (post-2011) and must continue to be collected routinely and on a regular

The colour denotes whether the latest district value is better or worse than the national value or target value. This is currently only provided for Kent level data.

Looking at the latest district data from June 2016 the following areas are significantly better than the national average:

- Child Poverty (% of children under 16 in low income families)
- GCSE Attainment (% achieving 5 good GCSEs A*-C including English and Maths)
- Households that experience fuel poverty (%) (low income, high cost methodology)

These areas are significantly worse than the national average:

- Statutory Homelessness Acceptances (per 1000 households)
- Admission episodes for alcohol-related conditions (ASR per 100,000)
- Excess winter deaths (single year, all ages/person)

Whereas, these are not significantly different than the national average:

- Excess weight in adults
- Killed and seriously injured on roads, crude rate per 100,000
- Emergency readmissions within 30 days of discharge from hospital

Health Inequalities Indicators for [District] 2016

The colour denotes whether the latest district value is better or worse than the national value or target value.
The trend line denotes the trend in the district over the recent history

District significantly better than national rate = Green
District significantly worse than national rate = Red
District not significantly different from national = Yellow

Lifecourse Stage	Indicator	Indicator Description	National (latest)	Kent (latest)	District (prior)	District (latest)	Performance Indicator	Latest Data Period
INFANCY	Infant Mortality	Infant mortality (rate per 1000 live births)	4.0	2.9	2.1	1.5	↓	2012-2014
	Smoking in Pregnancy	Smoking status at time of delivery (as % of maternities)	11.4%	12.60%	No data published	9.41		2014/15
	Breast Feeding	Breast feeding initiation (as % of maternities)	74.3%	71.30%	77.7%	75.8%	↓	2014/15
	Teen pregnancy	Under 18 Conceptions (rate per 1,000 females aged 15-17)	22.8	22.2	15.6	18	↑	2014
	Childhood Obesity (YR)	Excess weight in 4-5 year olds (% of children overweight or obese)	21.9%	22.5%	16.6%	20.6%	↑	2014/15
CHILDHOOD	Childhood Obesity (Y6)	Excess weight in 10-11 year (% of children overweight or obese)	33.2%	32.8%	31.4%	31.5%	↑	2014/15
	Childhood Poverty	Childhood Poverty (% of children under 16 in low income families)	18.6%	17.3%	14.0%	13.3%	↓	2013
	Education (attendance)	Pupil Absence (% half days missed due to unauthorised/authorised absence 5-15yr olds)	4.51%	4.70%	5.10%	4.4%	↓	2013/14
	Education (attainment)	GCSE Attainment (% achieving 5 good GCSEs A*-C including English and Maths)	56.8%	58.0%	70.8%	64.8%	↓	2013/14
	Childhood injuries	Hospital admission caused by injuries in children (aged 0-14 years) per 10,000 population	109.6	103.0	92.6	88.5	↓	2013/14
ADULTS	Unemployment	Longterm Unemployment (per 1000 of working age population)	7.1	5.6	5.5	3.3%	↓	2014
	Homelessness	Statutory Homelessness Acceptances (per 1000 households)	2.4	1.9	2.4	3.2	↑	2014/15
	Violent Crime	Violent crime (violence offences, crude rate per 1000 population)	13.5	15.6	14.2	15	↑	2014/15
	Healthy Eating	Proportion of population meeting the recommended '5-a day'	52.3%	56.2%	58.4%	56.9%	↓	2015
	Healthy Weight	Excess weight: excess weight in adults	64.6%	65.1%	-	65.5%		2012-2014
	Physical Activity	Physical Inactivity (<30mins per week of moderate activity)	27.7%	28.4%	25.2%	25.4%	↑	2014
	Smoking	Smoking prevalence in adults (%) (from integrated household survey)	18.0%	19.1%	14.5%	17.3%	↑	2014
	Alcohol	Admission episodes for alcohol-related conditions (Broad) (ASR per 100,000)	2120	1695	1589	1620	↑	2014/15
	Road Injuries	Killed and seriously injured on roads, crude rate per 100,000	39.3	39.6	38.6	40.6	↑	2012-14
ELDERLY	Fuel Poverty	Fuel Poverty - households that experience fuel poverty (%) (low income, high cost methodology)	10.4%	8.6%	7.9%	7.8%	↓	2013
	Winter Deaths	Excess winter deaths index (single year, all ages/persons)	11.6	13.8	31.2%	15.6%	↓	2013/14
	Falls	Injuries due to falls in people aged 65 and over (ASR per 100,000)	2125	2201	2415	2438	↑	2014/15
	Hip Fractures	Hip Fractures in people aged 65 and over (ASR per 100,000)	571	598	576	624	↑	2014/15
	Readmissions	Emergency readmissions within 30 days of discharge from hospital (Persons)	11.8	11.9	10.9	11.5%	↑	2011/12
	Cancer Screening (Breast)	Cancer Screening Coverage - Breast Cancer - % of eligible women screened in prior 3 years	75.4%	77.0%	79.6%	79.6%	↔	2015
	Cancer Screening (Cervical)	Cancer Screening Coverage - Cervical Cancer - % of eligible women screened in prior 3.5 or 5.5 years	73.5%	77.1%	78.6%	78.2%	↓	2015
	Cancer Screening (Bowel)	Cancer screening coverage - bowel cancer - % of eligible people screened in previous 2.5 years	57.1%	58.1%	-	62.7%		2015
	Place of Death	Percentage of deaths that occur in hospital	47.4%	41.7%	48.7%	46.1%	↓	2015
	Place of Death	Percentage of deaths that occur in Usual Place of Residence	44.7%	46.2%	45.9%	48.2%	↑	2015
MORTALITY	Premature Mortality	Premature mortality from all causes, under 75, (ASR per 100,000)	337.0	318.0	298	304	↑	2012-2014
	Premature Mortality (cardio)	Under 75 mortality rate from cardiovascular disease considered preventable (ASR per 100,000)	75.7	70.9	64.3	64.0	↓	2012-2014
	Premature Mortality (resp)	Under 75 mortality rate from respiratory disease considered preventable (ASR per 100,000)	32.6	30.9	31.1	30.3	↓	2012-2014
	Premature Mortality (cancer)	Under 75 mortality rate from cancer considered preventable (ASR per 100,000)	83	78.4	76.2	75.8	↓	2012-2014
	Premature Mortality (liver)	Under 75 mortality rate from liver disease considered preventable (ASR per 100,000)	15.7	13.7	10.7	14.2	↑	2012-2014
	Air-pollution-related Mortality	Fraction of mortality attributable to air pollution (PM2.5) (% of all age all cause mortality)	5.3%	5.4%	5.1%	5.5%	↑	2013
	Communicable Disease Mortality	Mortality from communicable disease (ASR per 100,000)	63.2	64.4	75.2	69.5%	↓	2010-2012
	Smoking-related Mortality	Smoking-related deaths (ASR pr 100,000)	279.0	266.7	-	256.1		2011-2013
	Alcohol-related Mortality	Alcohol-related mortality (ASR per 100,000)	45.5	42.4	46.0	41.9	↓	2014
	Suicide	Suicide age-standardised rate per 100,000 (3 year average)	8.9	10.2	8.7	10.1	↑	2012-14
	Preventable Mortality	Mortality rate from causes considered preventable	182.7	169.8	159.8	162.4	↑	2012-2014
	Life Expectancy (male)	Life expectancy at birth - years (male)	79.5	80.1	80.2	80.4	↑	2012-2014
	Life Expectancy (female)	Life expectancy at birth - years (female)	83.2	83.6	83.6	83.4	↓	2012-2014
	Life Expectancy Gap (males)	Slope index of inequality in life expectancy at birth based on local deprivation deciles - years (males)	9.2	7.4	5.4	5.6	↑	2012-2014
	Life Expectancy Gap (females)	Slope index of inequality in life expectancy at birth based on local deprivation deciles - years (females)	7.0	4.4	3.8	3.2	↓	2012-2014

Kent Public Health approach to health inequalities

Kent County Council, Mind the Gap strategy came to an end in 2015. The County Council's new strategy 'Mind the Gap 2016' is currently in draft format. This strategy is not time-bound as changes to health inequalities are recognised over longer periods of time.

Kent County Council is concentrating on lower super output areas in each district with the aim of community transformation; empowering individuals and communities for better health and wellbeing. This will be achieved through community 'asset based' approach.

Needs based approach	**Asset based approach**
Focus on deficiencies	Focus on strengths
Respond to problems	Identify opportunities
Provide services to users	See residents as co-producers
Short term solutions	Sustainable long-term change
Top down: residents have little say in local issues	Bottom up: empower residents to be part of the process

It is a unified plan that recognises improving the health of an entire population does not necessarily address the health inequalities that exists between different parts of the society. Closing the 'health gap' will require a faster improvement in health in the most deprived areas.

Within Maidstone, Kent County Council has recognised Lower Super Output Areas (LSOA) of Park Wood, Shepway South and High Street as areas of deprivation. They have adopted Chris Bentley's Ten Point Plan of 'System and Scale into Community Empowerment' to tackle health inequalities within these areas.

1. Prioritisation of areas – most in need
2. Defining communities – should be self-defining where possible
3. Asset mapping – stocktake of positive resources in place
4. Behaviour of Partners – agreed ways of working and sharing resources
5. Community profiles - collating top-down and bottom-up
6. Neighbourhood Action Plans (NAPS) – linking aspirations and objectives
7. Community based research (CBR) – train residents to be involved
8. Outreach models – using community venues
9. Community Links Strategy – gathering intelligence from community infrastructures
10. Transfer of Service Ownership – appropriate segments

Maidstone's approach to health inequalities

As a district council we are in a unique position to help Kent County Council Public Health deliver a health agenda particularly around the wider determinants of health.

A whole systems approach to public health can ensure our actions have a positive impact on public health, taking on more of an enabling role in the health of our residents and communities, ensuring actions are cost-effective and, where possible, offer a positive return on investment. Health Inequalities should be a major focus within this approach but should not be the 'sole' public health strategy but form part of a wider public health strategy as at county level.

Our health is primarily determined by factors other than health care. District councils are in a good position to influence many of these factors through their key functions and in their wider role supporting communities and influencing other bodies.

So how can Maidstone Borough Council achieve a whole systems approach to improving the health and wellbeing of our residents?

1. **Working in partnership and alignment**

We need to work in partnership with other agencies, ranging from Public Health England and other tiers of local government and directors of Public Health, to the local NHS, the voluntary and business sectors and communities themselves. This will enable us to share resources and achieve results.

2. To demonstrate effectiveness and return on investment

We should be more proactive in collating existing evidence on the health economics of our activities in order to guide decisions on our communities' health and wellbeing.

This could help us in attracting funds and other forms of support from other bodies, including health and higher tiers of local government.

3. To lead innovation in services and their delivery

Invest in health impact assessments (HIA) to move beyond innovative case studies to processes to show demonstrable improvements in health outcomes.

4. To strength our enabling role in the health of our communities

Actively engage with our communities involving them directly in decisions which affect their health and wellbeing.

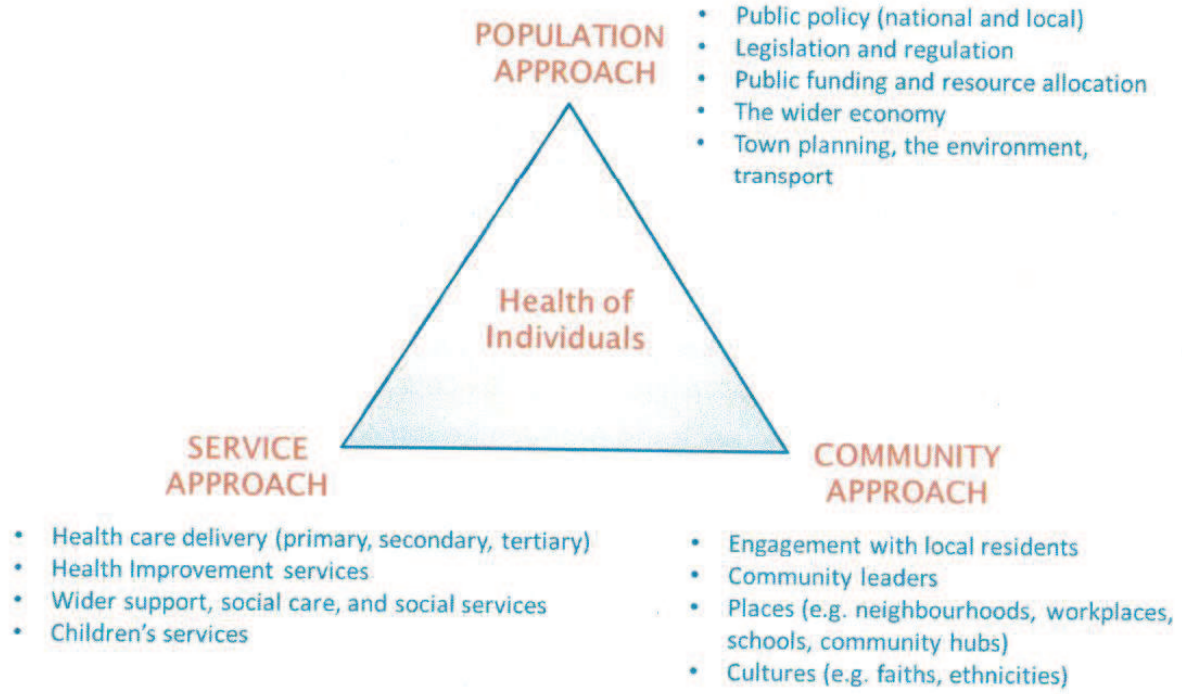
There is growing recognition that although disadvantage social groups and communities have a range of complex and inter-related needs, they also have assets at the social and community level that can help improve health, and strengthen resilience to health problems.

Recommendations

1. To embed health within the culture of Maidstone Borough Council to deliver a whole systems approach producing a 'District Health Deal' with Kent County Council Public Health.

2. Produce and deliver a learning and development package to staff and councillors on the importance of health and how their role contributes and can contribute further to improving health and wellbeing of residents. This will include embedding this approach in the Council's Business Plan and appraisals.

3. Support the implementation and delivery of the Mind the Gap 2016 which focuses on a community asset based approach in lower super output (Parkwood, Shepway and High Street ward). We are close enough to our communities to understand how they work and how to best reach and support them.



Model for impacting health at a population level (Chris Bentley 2012)

4. Establish a good working relationship with the Kent Public Health Department so health data is readily available dependant on the needs and change of our population. Using their expertise to understand what is underneath the data and what the intelligence tells us which must include qualitative information. (Intelligence based approach)

5. Establish collaborative working agreements (internal) and partnership working agreements (external) for partners to work together on achieving shared outcomes in improving resident health and wellbeing.

6. Produce Health Impact Assessments on all future strategies produced by Maidstone Borough Council.

7. Review progress of health inequalities to date and implement a refreshed action plan examining strategic direction for future delivery.

8. To confirm key objectives and priorities for the refreshed health inequalities action plan, taking note of significant trends highlighted by data provided by the Public Health Stakeholders.

   Community Context:
   - Violent Crime
   - Statutory homelessness

   Children and Young People:
   - Breastfeeding initiation and maintenance at 6/8 weeks
   - Excess weight in children
   - Teenage Conceptions and Teenage Parents
   - Emotional Health and Wellbeing (linked to admissions for injuries)

   Adults:
   - Emotional and Mental Health including social isolation
   - Alcohol
   - Excess Weight
   - Smoking
   - Dementia Prevention – physical activity, smoking cessation

   With regards to populations of people: young parents; Black and Minority Ethnic (BME); older people and homeless individuals are recommended.

   The priorities above have been identified by: looking at public health outcomes; appraising data available; benchmarking against England, South East, Kent and other wards; looking at trends; and identifying actions and making links to strategic priorities for Kent.

References

Maidstone Health Inequalities Action Plan 2014-2020

Kent County Council, Mind the Gap: Kent's Health Inequalities Action Plan 2012-2015

Kent County Council, Mind the Gap 2016

The Marmot Review, 'Fair Society, Healthy Lives', 2010

The Kings Fund, The district council contribute to public health: a time of challenge and opportunity

Data Sources

Kent and Medway Public Health Observatory
http://www.kpho.org.uk/

Public Health England
https://www.gov.uk/government/organisations/public-health-england

Public Health Profiles
http://fingertips.phe.org.uk/profile/health-profiles

REFRESH 2016

Maidstone Health Inequalities Action Plan

2014 - 2020

Contents

Foreword

In Maidstone we are committed to improving the health and wellbeing of our borough. We are also committed to reducing the health inequalities that exist across the area.

District Councils have a key role to play in keeping our population healthy. We have a distinct, local role in service provision, economic development, planning, and helping to shape and support our communities – all key areas that are increasingly recognised as vital components of a true population health system.

Health Inequalities are preventable and unjust differences in health status experienced by certain population groups. Everyone should have the same opportunity to lead a healthy life no matter where they live or who they are, which is why we must continue to narrow the gap in health inequalities. Organisation across the Maidstone borough must work together to address the health needs of their population and make a real difference in tackling health inequalities.

We want to ensure that, wherever possible, an individual's health and wellbeing is not determined by the area in which they were born, or in which they live.

The Maidstone Health Inequalities Action Plan which was adopted in 2014 provides the opportunity to review progress against actions and move forward in closing the gap in health inequalities. Since the development of the plan, data has developed, knowledge has matured and we face an ever-changing financial climate.

The Maidstone Health and Wellbeing Board will be the key mechanism to ensure that priorities for health and wellbeing in our area are identified and driven forward.

We are committed to ensuring that the Maidstone Health Inequalities Action Plan is implemented in a way which ensures that the benefits of health and wellbeing are available to all residents across the borough.

Alison Broom
Chief Executive

Introduction

What are Health Inequalities?

Health Inequalities are the differences in the health of different parts of the population. For example, people in more deprived areas have a shorter life expectancy than those who live in less deprived areas. Inequalities also exist in other aspects of people's health – for example, people in more deprived areas tend to smoke more, drink more alcohol, and are more likely to experience long-term illness. Inequalities also exist between groups accordingly to other factors such as gender, ethnic background, certain sorts of disability and sexual orientation.

What leads to inequalities?

There are a number of factors which lead to Health Inequalities. Most experts tend to place these factors into a small number of groups – such as those listed below. It is important, however, to bear in mind that experts think of these as the factors which are likely to lead to poorer health. There is every reason to believe that people can live healthy lives even in the harshest circumstances.

Social Factors

These are issues which affect the population as a whole, but do not necessarily affect everybody equally. Examples include government policies, the availability of work, general levels of wages, taxation and how much things cost – particularly the prices of essentials such as fuel, transport, food and clothing.

Living and working conditions

These include the important issues such as education, training, employment, housing, public transport and amenities. It also includes basic facilities like reliable utility supplies (gas, water and electricity) and being able to get hold of essential goods like food and clothing.

Social and Community networks

A person's "network" includes his or her family, friends and social circles – and the way all of those people together support, influence, advise and guide the individual. A strong network of family and friends can help to ensure than an individual has a healthy lifestyle. Sometimes, individuals living alone may not have any "network" sometimes the "network" can have an unsupportive effect, such as encouraging the consumption of alcohol to excess.

Individual lifestyle factors

These are sometimes described as lifestyle choices, because they tend to refer to things that people can generally choose to do, or not do. This would include things such as smoking, alcohol consumption, and drug use, whether people eat healthily and whether they take regular physical exercise. These choices are

influenced by the environment in which the individual lives – how friends and family act, how products are advertised and so on.

Healthcare factors

There is evidence to suggest that sometimes the parts of the population in the greatest need are poorly understood. This can mean that services are constructed and commissioned to address the needs of the whole populations, but not in such a way that inequalities are addressed.

Additionally, low-cost healthcare is sometimes under-used in a population. When this happens, it tends to be the most deprived parts of the population who are worst affected, because illness and disease is most prevalent in those areas. This therefore leads to a widening of the gap between the most and least deprived areas of a population.

Personal factors

These include some of the basic definitions of who people are: age, sex, ethnicity and genetic factors. There is nothing that can be done to change these factors – but understanding more about the population can help us to develop strategies, policies and practices.

National Context

The latest national strategy to tackling health inequalities, "Fair Society, Healthy Lives", was released in 2010 and is also known as the Marmot Review. Summarising the wealth of new research into health inequalities that had occurred since the previous national strategies into health inequalities; the Acheson Report (1998) and the Black Report (1980), the Marmot Review particularly stressed the action that would be required on the social determinants of health, such as education and employment. It also recognised that inequalities accumulates as we age, beginning even before birth. The six main policy objectives (below) take a 'life-course approach', from the early years through to ageing.

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

Delivering these policy objectives will require action by central and local government, the NHS, the voluntary and community sector and private sectors. National policies will not work without effective local delivery systems focused on health equity in all policies.

Kent County Council, Health Inequalities Strategy, Mind the Gap 2016 supports and follows the policy objectives suggested by Sir Michael Marmot. Kent County Council's approach to tackling health inequalities is Community Transformation. This is a means of empowering individuals and communities for better health and wellbeing. Kent County Council aim to radically improve health and wellbeing of identified communities, through coordinated actions across KCC, district councils, CCG's, service providers and community partners.

Health Inequalities in Maidstone

Taking into account our current Health Inequalities Action Plan and the need to understand what data is available; Public Health England have a list of indictors which have been considered and organised across the life course, consistent with the national strategy for tackling health inequalities. Indicators have been selected based on:

- Each indicator must relate to health inequalities (e.g. social determinants of health, health behaviours, health service uptake/use, health outcomes)
- Indicators collectively cover a wide breadth of issues, but minimising overlap
- Data for each indicators must be collected in a robust way, and consistent methodology, at least at County level, and ideally at District level (indicated where this is the case)
- Must be accessible on Public Health England (PHE) Fingertips website, for ease of access: fingertips.phe.org.uk/
- Data for each indicator must have been collected recently (post-2011) and must continue to be collected routinely and on a regular basis

The colour denotes whether the latest district value is better or worse than the national value or target value. This is currently only provided for Kent level data.

Data from June 2016 shows, life expectancy is 5.4 years lower for men and 3.8 years lower for women in the most deprived areas of Maidstone than the least deprived areas. The neighbourhoods that make up the areas of higher deprivation lie particularly in the electoral Wards of: Park Wood; High Street; Shepway North; and Shepway South.

The following areas are significantly better than the national average:

- Child Poverty (% of children under 16 in low income families)
- GCSE Attainment (% achieving 5 good GCSEs A*-C including English and Maths)
- Households that experience fuel poverty (%) (low income, high cost methodology)

These areas are significantly worse than the national average:

- Statutory Homelessness Acceptances (per 1000 households)
- Admission episodes for alcohol-related conditions (ASR per 100,000)
- Excess winter deaths (single year, all ages/person)

Whereas, these are not significantly different than the national average:

- Excess weight in adults
- Killed and seriously injured on roads, crude rate per 100,000
- Emergency readmissions within 30 days of discharge from hospital

Health Inequalities Indicators for Maidstone 2016

The colour denotes whether the latest district value is better or worse than the national value or target value.
The trend line denotes the trend in the district over the recent history

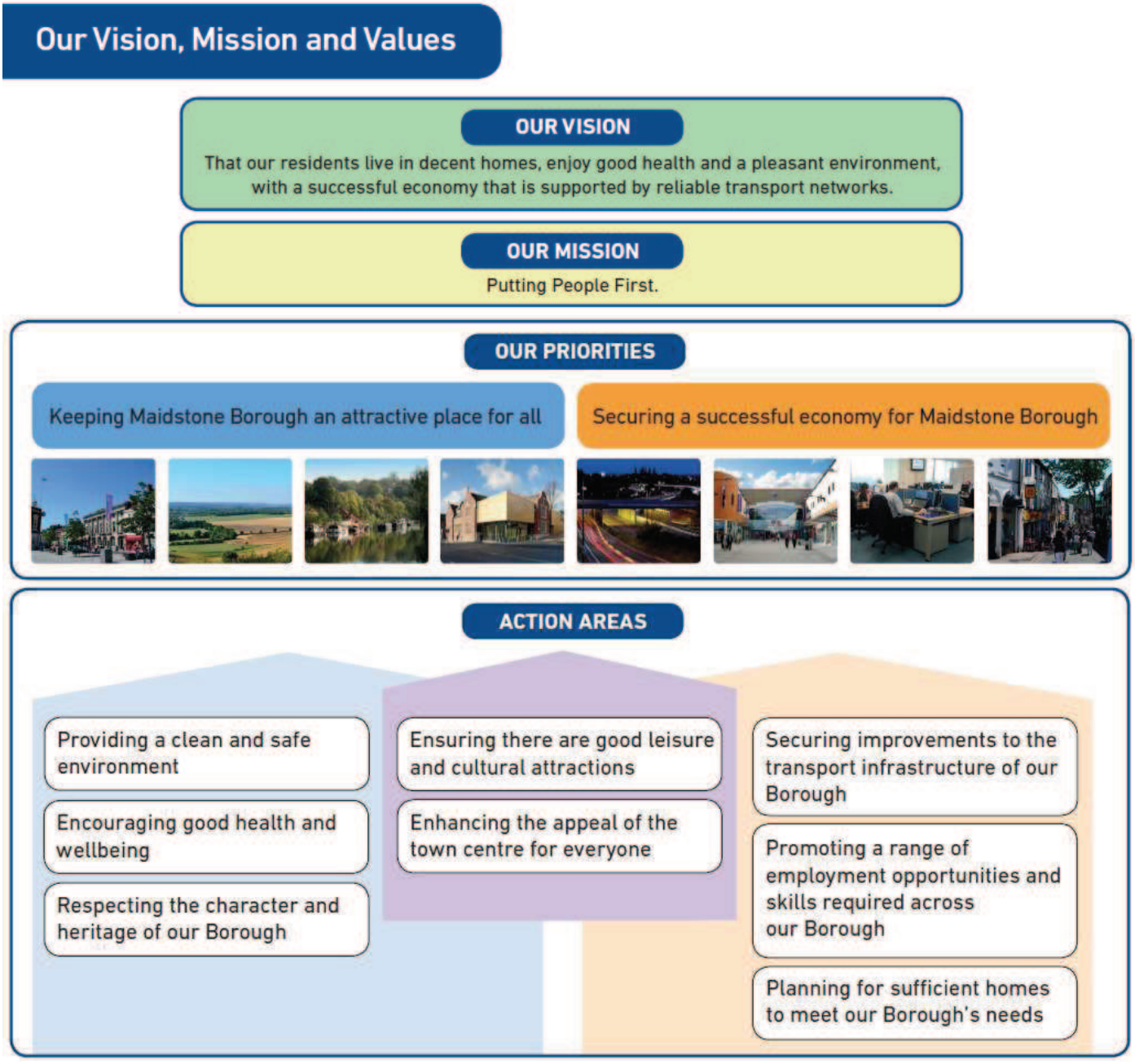
District significantly better than national rate = Green
District significantly worse than national rate = Red
District not significantly different from national = Yellow

Lifecourse Stage	Indicator	Indicator Description	National (latest)	Kent (latest)	District (prior)	District (latest)	District (trend)	Latest Data Period
INFANCY	Infant Mortality	Infant mortality (rate per 1000 live births)	4.0	2.9	2.1	1.5		2012-2014
	Smoking in Pregnancy	Smoking status at time of delivery (as % of maternities)	11.4%	12.60%	No data published	9.41		2014/15
	Breast Feeding	Breast feeding initiation (as % of maternities)	74.3%	71.30%	77.7%	75.8%		2014/15
	Teen pregnancy	Under 18 Conceptions (rate per 1,000 females aged 15-17)	22.8	22.2	15.6	18		2014
	Childhood Obesity (YR)	Excess weight in 4-5 year olds (% of children overweight or obese)	21.9%	22.5%	16.6%	20.6%		2014/15
CHILDHOOD	Childhood Obesity (Y6)	Excess weight in 10-11 year (% of children overweight or obese)	33.2%	32.8%	31.4%	31.5%		2014/15
	Childhood Poverty	Childhood Poverty (% of children under 16 in low income families)	18.6%	17.3%	14.0%	13.3%		2013
	Education (attendance)	Pupil Absence (% half days missed due to unauthorised/authorised absence 5-15yr olds)	4.51%	4.70%	5.10%	4.4%		2013/14
	Education (attainment)	GCSE Attainment (% achieving 5 good GCSEs A*-C including English and Maths)	56.8%	58.0%	70.8%	64.8%		2013/14
	Childhood injuries	Hospital admission caused by injuries in children (aged 0-14 years) per 10,000 population	109.6	103.0	92.6	88.5		2013/14
ADULTS	Unemployment	Longterm Unemployment (per 1000 of working age population)	7.1	5.6	5.5	3.3%		2014
	Homelessness	Statutory Homelessness Acceptances (per 1000 households)	2.4	1.9	2.4	3.2		2014/15
	Violent Crime	Violent crime (violence offences, crude rate per 1000 population)	13.5	15.6	14.2	15		2014/15
	Healthy Eating	Proportion of population meeting the recommended '5-a day'	52.3%	56.2%	58.4%	56.9%		2015
	Healthy Weight	Excess weight: excess weight in adults	64.6%	65.1%	-	65.5%		2012-2014
	Physical Activity	Physical Inactivity (<30mins per week of moderate activity)	27.7%	28.4%	25.2%	25.4%		2014
	Smoking	Smoking prevalence in adults (%) (from integrated household survey)	18.0%	19.1%	14.5%	17.3%		2014
	Alcohol	Admission episodes for alcohol-related conditions (Broad) (ASR per 100,000)	2120	1695	1589	1620		2014/15
	Road Injuries	Killed and seriously injured on roads, crude rate per 100,000	39.3	39.6	38.6	40.6		2012-14
ELDERLY	Fuel Poverty	Fuel Poverty - households that experience fuel poverty (%) (low income, high cost methodology)	10.4%	8.6%	7.9%	7.8%		2013
	Winter Deaths	Excess winter deaths index (single year, all ages/persons)	11.6	13.8	31.2%	15.6%		2013/14
	Falls	Injuries due to falls in people aged 65 and over (ASR per 100,000)	2125	2201	2415	2438		2014/15
	Hip Fractures	Hip Fractures in people aged 65 and over (ASR per 100,000)	571	598	576	624		2014/15
	Readmissions	Emergency readmissions within 30 days of discharge from hospital (Persons)	11.8	11.9	10.9	11.5%		2011/12
	Cancer Screening (Breast)	Cancer Screening Coverage - Breast Cancer - % of eligible women screened in prior 3 years	75.4%	77.0%	79.6%	79.6%		2015
	Cancer Screening (Cervical)	Cancer Screening Coverage - Cervical Cancer - % of eligible women screened in prior 3.5 or 5.5 years	73.5%	77.1%	78.6%	78.2%		2015
	Cancer Screening (Bowel)	Cancer screning coverage - bowel cancer - % of eligible people screened in previous 2.5 years	57.1%	58.1%	-	62.7%		2015
	Place of Death	Percentage of deaths that occur in hospital	47.4%	41.7%	48.7%	46.1%		2015
	Place of Death	Percentage of deaths that occur in Usual Place of Residence	44.7%	46.2%	45.9%	48.2%		2015
MORTALITY	Premature Mortality	Premature mortality from all causes, under 75, (ASR per 100,000)	337.0	318.0	298	304		2012-2014
	Premature Mortality (cardio)	Under 75 mortality rate from cardiovascular disease considered preventable (ASR per 100,000)	75.7	70.9	64.3	64.0		2012-2014
	Premature Mortality (resp)	Under 75 mortality rate from respiratory disease considered preventable (ASR per 100,000)	32.6	30.9	31.1	30.3		2012-2014
	Premature Mortality (cancer)	Under 75 mortality rate from cancer considered preventable (ASR per 100,000)	83	78.4	76.2	75.8		2012-2014
	Premature Mortality (liver)	Under 75 mortality rate from liver disease considered preventable (ASR per 100,000)	15.7	13.7	10.7	14.2		2012-2014
	Air-pollution-related Mortality	Fraction of mortality attributable to air pollution (PM2.5) (% of all age all cause mortality)	5.3%	5.4%	5.1%	5.5%		2013
	Communicable Disease Mortality	Mortality from communicable disease (ASR per 100,000)	63.2	64.4	75.2	69.5%		2010-2012
	Smoking-related Mortality	Smoking-related deaths (ASR pr 100,000)	279.0	266.7	-	256.1		2011-2013
	Alcohol-related Mortality	Alcohol-related mortality (ASR per 100,000)	45.5	42.4	46.0	41.9		2014
	Suicide	Suicide age-standardised rate per 100,000 (3 year average)	8.9	10.2	8.7	10.1		2012-14
	Preventable Mortality	Mortality rate from causes considered preventable	182.7	169.8	159.8	162.4		2012-2014
	Life Expectancy (male)	Life expectancy at birth - years (male)	79.5	80.1	80.2	80.4		2012-2014
	Life Expectancy (female)	Life expectancy at birth - years (female)	83.2	83.6	83.6	83.4		2012-2014
	Life Expectancy Gap (males)	Slope index of inequality in life expectancy at birth based on local deprivation deciles - years (male	9.2	7.4	5.4	5.6		2012-2014
	Life Expectancy Gap (females)	Slope index of inequality in life expectancy at birth based on local deprivation deciles - years (fema	7.0	4.4	3.8	3.2		2012-2014

Priorities

Local authorities are uniquely placed to tackle health inequalities, as many of the social and economic determinants of health, and the services or activities which can make a difference, fall within their remit. Services include: planning, housing, economic development, environmental health, leisure, licensing and community safety.
The challenge is to reduce the difference in mortality and morbidity rates between rich and poor and to increase the quality of life and sense of wellbeing of the whole local community.

Maidstone Borough Council's commitment to improve resident's health and wellbeing is set out in their Strategic Plan 2015 – 2020.



Public health is at the heart of local authorities roles with cross-cutting objectives in tackling health inequalities.

This action plan outlines our collective commitment and actions for improving the health of populations within the borough. Our approach will be targeted and proportionate, helping to close the gap between the least and most deprived. Sir Michael Marmot's life course approach is the foundation for this plan; based on 6 policy areas.

Implementation

The Maidstone Health Inequalities Action Plan will be implemented by the Council and its partners through the detailed action plan set out below.

The Action Plan provides a framework and tools to identify, analyse partnership actions that will contribute to reducing health inequalities in the Maidstone Borough.

The Maidstone Health and Wellbeing Board will not be responsible for directly commissioning services but will provide oversight, strategic direction and coordination. The Group will own the action plan, but will not be the sole owner of the actions contained within it. The structure of the Maidstone Health and Wellbeing Board contains the following sub-groups:

- Ageing Well
- Homelessness and Health
- Local Children's Partnership
- Skills and Employability

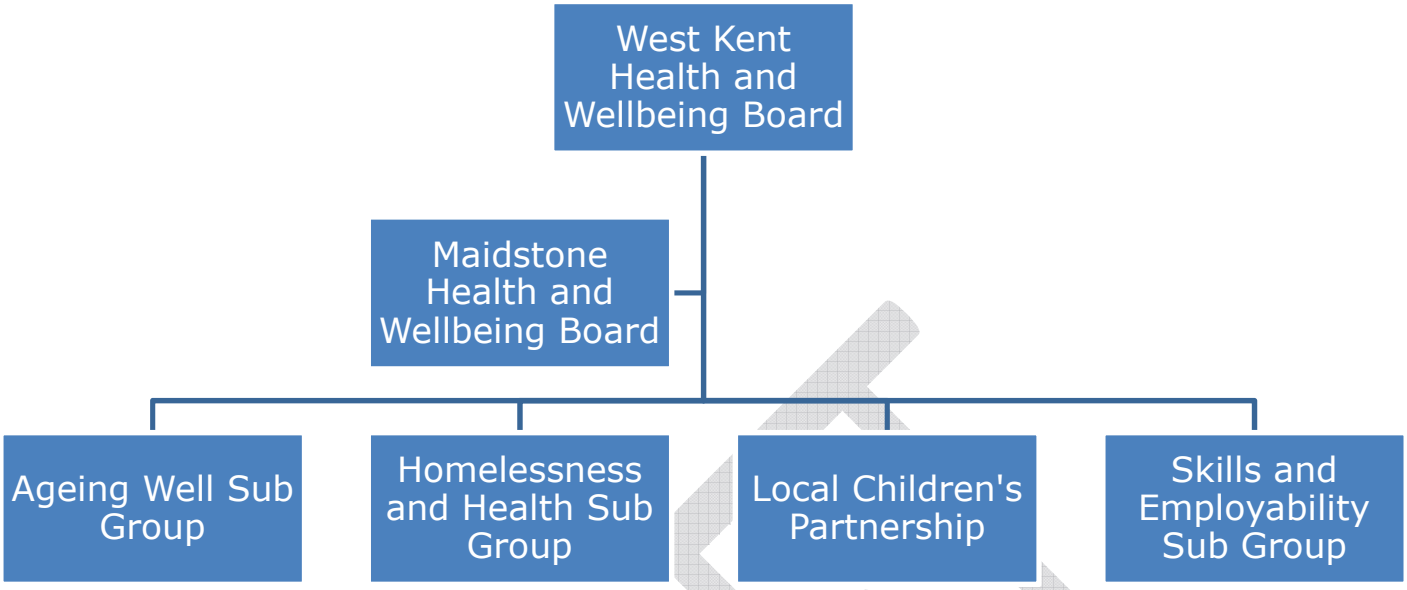
The sub-groups will co-opt members as appropriate to progress the work of the Health Inequalities Action Plan and requests from the Maidstone Health and Wellbeing Board.

Progress of the action plan will be reported to the West Kent Health and Wellbeing Board.

The Maidstone Health Inequalities Action Plan will be refreshed bi-annually to reflect progress and ensure that it remains current.

It is important to note that not all actions contained with the plan will be delivered by the Maidstone Health and Wellbeing Board. A number of key strategic partners and organisational strategies contribute to reduce health inequalities, such as: Kent County Council, Maidstone Borough Council, Clinical Commissioning Groups, and Voluntary and Community Sector.

Structure



The purpose of each sub group is:

Ageing Well

- To work together as partners organisations and communities to improve local health outcomes for older people and build on the strengths of our diverse borough.
- To make prevention and early intervention the principles that guide how resources are deployed in Maidstone to achieve our priority outcomes.

Homelessness and Health

- To assess the impact of homelessness on the health of people in the borough
- To assess the initiatives currently in place to tackle homelessness and to address the health needs of homeless and vulnerable people in the borough
- To make effort to hear the views and opinions of some of the individuals concerned and make recommendations to the Council, the NHS and other relevant organisation to address the needs of rough sleepers and improve their health outcomes.

Local Children's Partnership

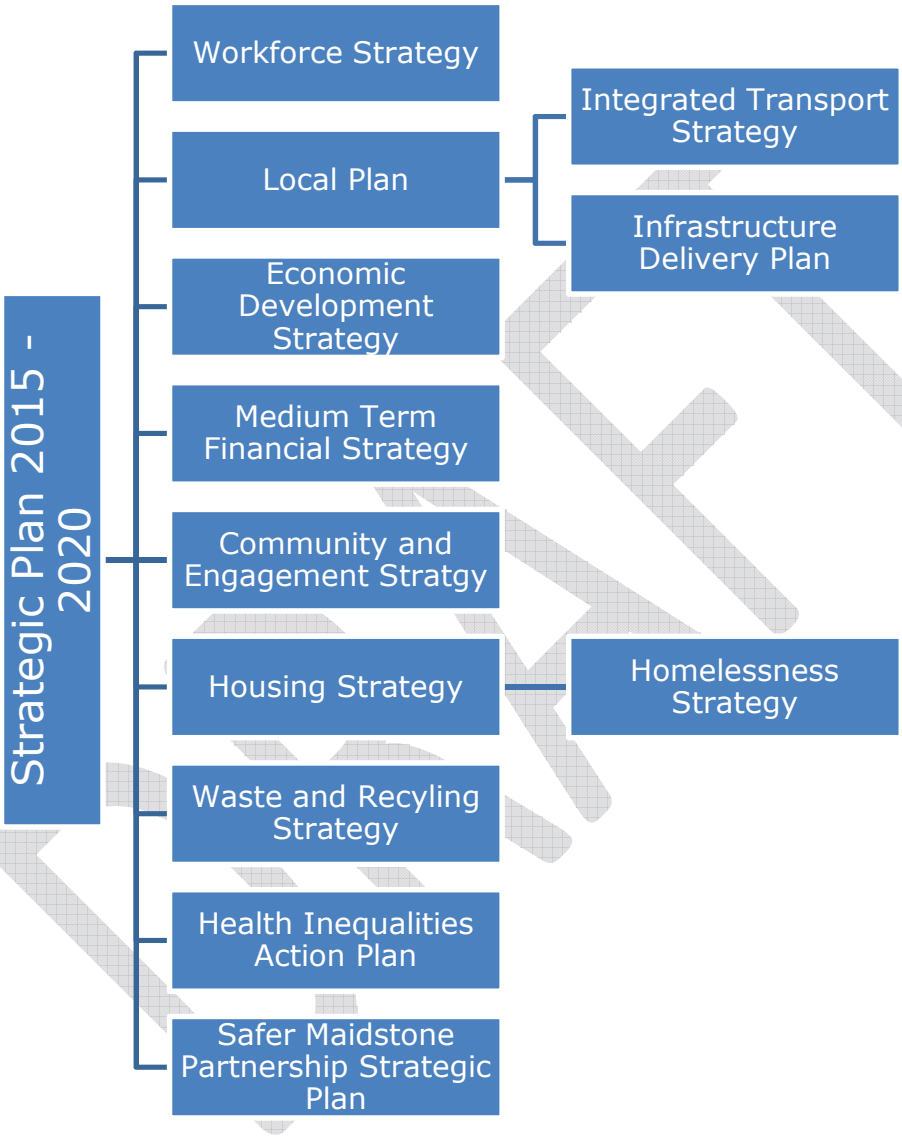
- Work in partnership at a district level and to drive improvement in specific outcomes for local children and young people.
- Sharing information to provide an understanding of local services and their thresholds.
- Providing a vehicle for identifying and addressing local needs and gaps in service provision.
- Facilitating and pooling resources to meet the needs of local children and families.

Skills and Employability

- To improve the employment prospects, education and skills of local people
- To support and promote growth in local economies and businesses to benefit local people.

The Marmot Priorities underpin the work of the subgroups by creating an enabling society that maximises individual and community potential; and to ensure social justice, health and sustainability.

The Health Inequalities Action Plan is not the only plan which tackles health inequalities among our residents. A number of other key plans and strategies contribute to improving the health and wellbeing and reducing the gap in inequality including:



The actions of the above strategies/plans have not been included within the Health Inequalities Action Plan and are being worked on outside of the Maidstone Health and Wellbeing Board.

Action Plan

Priority 1: Ageing Well

The work undertaken by the group feed in to the following Marmot priorities:

- Enable all children, young people and adults to maximise their capabilities and have control over their lives (Priority 2)
- Ensure a healthy standard of living for all (Priority 4)
- Create and develop healthy and sustainable places and communities (Priority 5)
- Strengthen ill-health prevention (Priority 6)

Relevant standards against which to monitor progress on this priority could include: falls and injuries in the over 65s; Hip fractures in over 65s; excess winter deaths; hospital stays in 65s and over; number of health checks completed by GP's; excess weight in adults; number of referrals for a disabled facilities grant; number of completed disabled facilities grant; life expectancy;

Theme	Commitment	Lead Sub-Group	Marmot Priorities
Support older people to live safe, independent and fulfilled lives	Improve social connectedness for older people Improve levels of volunteering and participation Promote independence and improve support for older people to stay in their own homes through provision of aids and equipment Support people to maximise their incomes through good welfare benefits advice, education and training and support to stay or return to employment.	Ageing Well	Priority 2 & 4
Ensure people experience services that support them to enjoy a good quality of life	Understand the local challenges facing older people accessing information and advice about local support services and opportunities People are helped to live healthy lifestyles, make healthy choices and	Ageing Well	Priority 2, 5 & 6

	reduce health inequalities To ensure that future generations of older people are well equipped for later life by encouraging recognition of the changes and demands that may be faced and taking action early in preparation		
Improve uptake of screening in most disadvantaged areas	Increase access to NHS health checks for 40 – 74 year olds	Ageing Well Homelessness and Health	Priority 6

Priority 2: Homelessness and Health

The work undertaken by the group feed in to the following Marmot priorities:

- Enable all children, young people and adults to maximise their capabilities and have control over their lives (Priority 2)
- Ensure a healthy standard of living for all (Priority 4)
- Create and develop healthy and sustainable places and communities (Priority 5)
- Strengthen ill-health prevention (Priority 6)

Relevant standards against which to monitor progress on this priority could include: statutory homelessness acceptances (per 1000 households); number of homeless preventions; number of households living in temporary accommodation; average length of stay in temporary accommodation; number of households supported to improve energy efficiency; number of properties improved;

Theme	Commitment	Lead Sub-Group	Marmot Priorities
Ensure Housing Policy is delivered in a way that prevents Housing contributing to Health Inequality	Reduce disrepair and health hazards to housing in the borough Increase opportunities to provide information around affordable warmth and energy efficiency Improve the quality of existing housing through a comprehensive programme of housing standards, advice, support, grants and enforcement (MBC's Housing Assistance Policy)	Homelessness and Health	Priority 2, 4 5 & 6
Reduce and prevent homelessness	Implementation and delivery of the Maidstone Homelessness Strategy 2014-2019 Implement homelessness prevention and assessment services Work in partnership to improve hospital discharge Reduce the negative impacts of temporary accommodation on homeless families	Homelessness and Health	Priority 2, 4 & 5

Promote opportunities to support people in poverty	Reduce barriers in registering and accessing services Provide support, advice and information to residents about debt management and financial awareness Promote support available to people in poverty e.g. Kent Saver's, food banks, Citizens Advice, KSAS	Homelessness and Health	Priority 4 & 5
Provide information and advice to families to promote ongoing welfare reform support	Develop and deliver financial inclusion partnership and action plan Implement communications strategy and continually review and update as more information is provided	Homelessness and Health	Priority 4 & 5
Improve uptake of screening in most disadvantaged areas	Increase access to NHS health checks for 40 – 74 year olds	Ageing Well Homelessness and Health	Priority 6

Priority 3: Local Children's Partnership

The work undertaken by the group feed in to the following Marmot priorities:

- Give every child the best start in life (Priority 1)
- Enable all children, young people and adults to maximise their capabilities and have control over their lives (Priority 2)
- Create fair employment and good work for all (Priority 3)
- Create and develop healthy and sustainable places and communities (Priority 5)
- Strengthen ill-health prevention (Priority 6)

Relevant standards against which to monitor progress on this priority could include: rate of infant deaths (persons aged less than one year) per 1,000 live births; low birth weight of term babies; breastfeeding; smoking status at time of delivery; under 18 conception; excess weight at reception and year 6; engagement in Maidstone Families Matters programme; GCSE's (5+ A* - C including Maths and English; Young people not in education, employment or training;

Theme	Commitment	Lead Sub-group	Marmot Priorities
Ensure good physical, mental and emotional health for all	Ensure mothers have good physical and emotional health in pregnancy and in the early months of life: focusing on increasing levels of breastfeeding and reducing smoking in pregnancy Encourage and support healthy growth and weight of children through healthy eating and physical activity Promote active travel to and from schools, children's centres and colleges Work to promote Maidstone as a breastfeeding friendly town Work with services who support families with complex needs e.g. Maidstone Families Matters	Local Children's Partnership	Priority 1, 2 & 5

	Increase the awareness and importance of good health and wellbeing for all through media and signposting to services		
Learn and have opportunities to achieve throughout their lives	To help young people and parents/carers to access the right pathways for learning and independence Work in partnership to identify and support children and young people not in education, employment or training Work alongside schools/colleges/universities to promote training appropriate for the skills needed in Maidstone	Local Children's Partnership Skills and Employability	Priority 1, 2 & 3
Make safe and positive decisions	Develop pathways for identifying children and young people 'at risk' of early sexual activity and teenage pregnancy and offer early intervention and support Promote appropriate relationships and increase emotional resilience Work collectively to increase access to services by providing information, advice and guidance on available services such as smoking, alcohol, domestic abuse	Local Children's Partnership	Priority 1 & 2

Priority 4: Skills and Employability

The work undertaken by the group feed in to the following Marmot priorities:

- Enable all children, young people and adults to maximise their capabilities and have control over their lives (Priority 2)
- Create fair employment and good work for all (Priority 3)

Relevant standards against which to monitor progress on this priority could include: number of healthy businesses in the borough; work related illness; long term unemployment (per 1000 of working age population); number of volunteers; unemployment; long term claimants of jobseekers allowance;

Theme	Commitment	Lead Sub-group	Marmot Priorities
Increase the number of healthy workplaces in the borough	Promote awareness of health issues within the workplace Work with employers to improve health and wellbeing in the workplace Encourage and support employees to adopt healthier lifestyles	Skills and Employability	Priority 3
Make employment accessible for all	Break the cycle of worklessness by undertaking positive action for vulnerable groups (low income families; unemployed adults; those who are NEET or at risk of becoming NEET) Develop quality and multiple work experiences and volunteering opportunities for people as a route in to work	Skills and Employability Local Children's Partnership	Priority 2 & 3
Increase the number of volunteering opportunities	Work with third sector organisations to increase levels of community volunteering and skills levels	Skills and Employability	Priority 3
Learn and have opportunities to achieve throughout their lives	To help young people and parents/carers to access the right pathways for learning and independence	Local Children's Partnership	Priority 1, 2 & 3

	Work in partnership to identify and support children and young people not in education, employment or training Work alongside schools/colleges/universities to promote training appropriate for the skills needed in Maidstone	Skills and Employability	
Increase the number of business start-ups	Encourage the establishment and growth of businesses (including self-employment) in the Borough to increase the choice of jobs Continued promotion of the Maidstone Business Terrace Support social enterprise growth including involvement of the third sector in service planning and delivery	Skills and Employability	Priority 3

Overarching commitments

The following themes and commitments work across all four sub-groups of the Maidstone Health and Wellbeing Board and should be considered as part of their development and delivery plans.

Relevant standards against which to monitor progress on this priority could include: self-reported wellbeing; excess weight in adults; number of staff trained to deliver 'making every contact count' interventions; percentage of physically active adults;

Theme	Commitment	Lead Agency	Marmot Priorities
Encourage self-care and access to health services for all	Build capacity to make sure people can take advantage of the opportunity to take control of their own health, and actively take part in improving the health and wellbeing of others Support hard to reach and vulnerable people who do not traditionally engage with health services		Priority 2 & 6
Promote an environment and culture that makes healthy lifestyles easier to achieve	Recognise the importance of safe places to take part in physical activity, whether that be active travel, community centres or health facilities and improve accessibility in a physical and monetary sense to ensure available to the wider community		Priority 2 & 5
Provide brief interventions and referrals to effective preventative services, using the principles of 'Making Every Contact Count'	Train and support front line staff to confidently raise the issues of lifestyle and behaviours and provide confident brief interventions and sign posting	All agencies	Priority 2
Create opportunities for individuals, groups and organisations to get together to discuss their circumstances, needs and aspirations, within and between communities and neighbourhoods	Support Kent Public Health in the delivery of their health inequalities action plan 'Mind the Gap' Promote asset mapping and community development	Maidstone Health and Wellbeing Board	Priority 5

Grow partnerships and find new works to target and deliver services	Work with the Health and Wellbeing Boards to support the delivery of key priorities set out in the health inequalities agenda		Priority 6
To implement strategies for promotion and prevention in mental health and wellbeing	Increase public knowledge and understanding about mental health and signpost to relevant services Create and enable resilient communities Promotion of Six Ways to Wellbeing Encourage services/businesses to be 'mental health friendly'		Priority 6
Reduce obesity rates across the borough	Support the delivery of the West Kent Obesity Action Plan Encourage healthy weight environments and discourage obesogenic environments	Maidstone Borough Council	Priority 6
Reduce number of people living with preventable ill-health and people dying prematurely while reducing the gap between communities	Promotion of healthy lifestyles through behaviours/choices, and the environment and communities people live Support national and local campaigns to highlight ongoing health issues (such as obesity, tobacco and substance misuse, dementia, social isolation)	All	Priority 2,4 & 6

References

Maidstone Health Inequalities Action Plan 2014-2020

Maidstone Health Inequalities 2015/16 Progress Report

Maidstone Borough Council's Communities, Housing and Environment Committee

Terms of Reference for Maidstone Health and Wellbeing Board and Sub-groups

Kent County Council, Mind the Gap: Kent's Health Inequalities Action Plan 2012-2015

Kent County Council, Mind the Gap 2016

The Marmot Review, 'Fair Society, Healthy Lives', 2010

The Kings Fund, The district council contribute to public health: a time of challenge and opportunity

To: **West Kent Health and Wellbeing Board**

Report from: **Hayley Brooks and Lesley Bowles, Sevenoaks District Council**

Date: **20 December 2016**

Subject: **Sevenoaks District Health Inequalities Action Plan**

Summary

This report provides an update on the objectives and actions being undertaken by Health Action Team partners to deliver priorities within the Sevenoaks District Health Inequalities Action Plan.

Recommendations

The Board is recommended to:

a) Consider and note the content of this report.

Background and Introduction

1 In 2013, all District Councils in Kent were asked to produce an action plan based on a County-wide template to deliver local objectives with partners to reduce health inequalities in their district. At facilitated 'Mind the Gap' workshops partners identified priorities under each objective and measurable actions to be delivered.

2 The first Sevenoaks District Health Inequalities Action Plan was adopted by Council Members on 5 December 2013. The two year (2013-2015) Plan provided a framework to identify, analyse and evaluate actions that can contribute to improving the health and wellbeing of residents.

3 The Action Plan is monitored and delivered by the quarterly Sevenoaks District Health Action Team partnership (HAT), co-ordinated by this Council. Key partners on the HAT include: Kent County Council, West Kent Housing Association, SDC Housing, Kent Community Health Trust, Children Centres, Learning Disability Partnership, Age UK, West Kent MIND, Seniors Action Forum, Sencio Community Leisure, Imago, West Kent and DGS CCGs, Alzheimers and Dementia Support Services and Moat Homes.

Mind the Gap Health Inequalities Action Plan

4 The Action Plan sets out six objectives to reduce health inequalities across the District:

- 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 a healthy standard of living for all;
- Create and develop healthy and sustainable places and communities;
- Strengthen the role and impact of ill health prevention.

5 The monitored outcomes and achievements feed into the Sevenoaks District Community Plan under the Healthy Environment and Caring Communities priorities.

2015/16 – Action Plan Annual Monitoring Summary

6 Sevenoaks District Council is responsible for monitoring the Action Plan in partnership with the Health Action Team. Monitoring data is collected from partners and reported at the quarterly Health Action Team meetings.

7 A target within the Communities and Business Service Plan was set for over 80% of actions to be on target. The 2015-16 annual monitoring summary of the Action Plan shows the following using a traffic light system to measure progress:

Green (on or exceeded target)	**81%**
Yellow (target not achieve)	**6%**
Red (Unlikely to be achieved)	**0%**
Purple (Data Missing)	**13%**

8 6% of the actions are yellow; this was made up of two actions in the plan. The stop smoking library service that was offered by KCC for the first time this year at the Sevenoaks site reached 52 people but was short by 8 to reach the target. The other action is a 6% increase in crime and anti social behaviour of which the Community Safety partnership continues to address.

9 At the end of the 2012-2015 Action Plan data comparisons, including the 2015 Health Profile compared to 2012, demonstrated the following outcomes had been achieved:

- A reduction in the number of children living in poverty (2,700 to 2,600)
- Slight increases in male and female life expectancies (from 81.2 to 81.4 for males, 83.9 to 84.6 for females)
- A decrease in the life expectancy gap between the most and least deprived wards with a reduction of 1.3 years (male from 4.5 to 3.2 years)
- A decrease in the percentage of children in Year 6 who are obese (reduced from 16.1% to 15.5%)
- Decreases in teenage pregnancies (21.1 to 13.7 per 1,000 females), in adults smoking (20.7% to 18.4%) and in infant mortality (3.5 to 2.8 per 1,000 live births)

However the same data identified the following areas of concern:

- An increase in numbers killed or seriously injured on our roads (45.1 to 51.8 per 100,000 population)
- Increases in smoking related deaths (164 to 236.1 per 100,00 population), excess winter deaths (17.6 to 19.6 ratio) and hip fractures in 65s and over (451 to 616 per 100,000 population)
- Increases in recorded diabetes (5.0% to 5.4%) and malignant melanoma (13.7 to 18.0 per 100,000 population)
- An increase in drug use (2.0 to 2.2 per 1,000 population)
- An increase in alcohol specific hospital stays for the under 18s (35.0 to 28.9 per 100,00 population)

Year End Key Achievements

10 The Action Plan demonstrates that through partnership working, we have exceeded the targets set for a number of key actions including:

- Number of outreach contraceptive outreach services increased to 4 in areas of need;
- Number of attendances at weekly health walks increased from 5,913 to 6,434
- Community engagement with Seniors Action Forum members doubled to 630 from 372;
- Young people engaging in targeted leisure activities in Swanley increased to 779 from 635;
- Over 500 young people per quarter accessed the Edenbridge HOUSE youth project;
- Number of people accessing leisure schemes for older people, home library services and Care Navigator support have all increased significantly;
- Attendances at chair based yoga and postural stability classes increased from 2,630 to 3,563;
- New external funded sports activities saw an additional 1,766 attendances at new physical activity sessions;
- Number of families attending Fun, Fit and Active activities in schools totalled 2,144 participants;
- Over 1,100 attendances at new Dementia café and support groups
- A total of 94 Disabled Facilities Grants approved to install home adaptations , exceeding the target of 80

11 Participant case studies demonstrating the key outcomes and positive impacts of this work can be found at Appendix B of this report.

New 2015-2018 Health Inequalities Action Plan

12 The new three year Action Plan (2015-18) was adopted by Council Members on 23 September 2015. Priorities from the previous Action Plan were reviewed and updated by partners using Health Profile data and local

intelligence. Partners identified the following six local priorities to deliver targeted actions for local residents, with a focus of areas of need:

i) Promote Healthy Weight for Children;
ii) Support older people to keep them safe, independent and living fulfilled lives;
iii) Support businesses to have healthy workplaces;
iv) Meet the housing needs of people living in the District including affordable and appropriate housing;
v) Sustain and support safe communities including;
vi) Reduce the gap in health inequalities across the social gradient.

13 At the half year stage of the first year's monitoring of the Plan, 81% of actions are on target. Full details of the year to date progress for 2016/17 are attached at Appendix A.

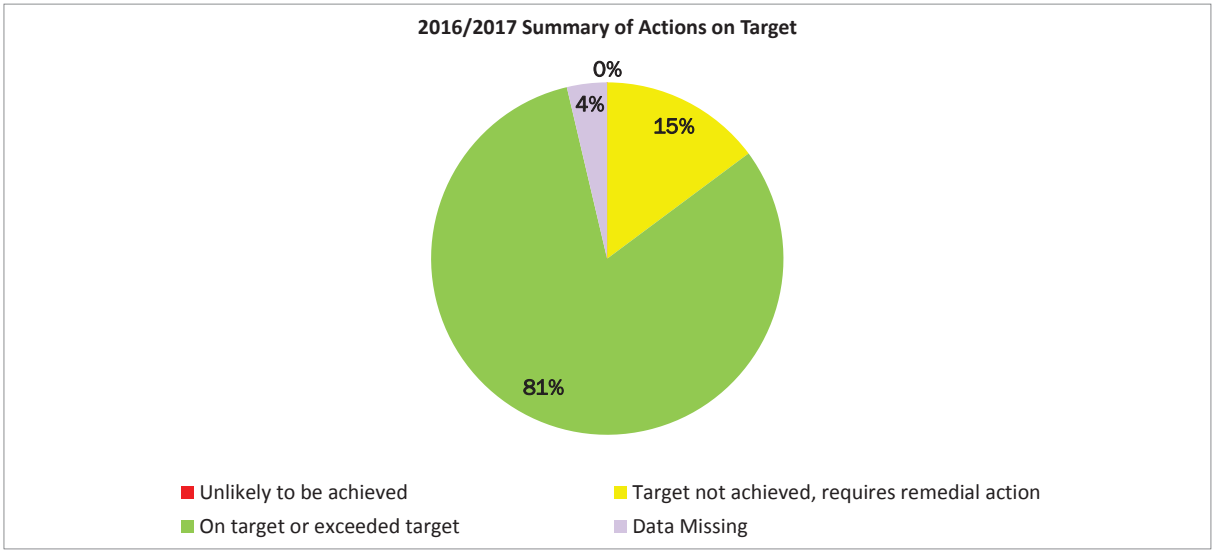
Conclusion

14 The Health Inequalities Action Plan is delivered through an integrated partnership approach to address identified health inequalities and improve the health and wellbeing of residents.

15 The Board is asked to note the contents of this report and acknowledge the progress made to deliver actions amongst local priorities within the Action Plan.

2015-2018 Sevenoaks District 'Mind the Gap' Health Inequalities Action Plan

2016-2017 End of Quarter 2 Summary



Ref. No.	Target	How is that measured?	Lead	15/16 Baseline	16/17 Target	16/17 Q1	16/17 Q2	Year DOT	Notes
1	**Promote Healthy Weight for Children**								
1.1	Support parents and children to maintain a healthy weight	Work with partners to support healthy weight initiatives for young people	SDC Healthy Living Team	2	50	**0**	**0**	**Green**	These programmes will be delivered in quarters 3 and 4. Six families (13 individuals) have already registered for the programme.
	Support parents and children to maintain a healthy weight	Attendances at family exercise/healthy living courses/workshops	Kent Adult Education	176	120	**31**	**37**	**Green**	
	Support parents and children to maintain a healthy weight	Number of Children Supported	School Health Team, KCHFT	2144	650	**316**	**0**	**Yellow**	There have been no events delivered in this quarter, due to the delivery officer role being vacant.
	Support parents and children to maintain a healthy weight	Number of Parents Supported	School Health Team, KCHFT	56		**0**	**0**	**Yellow**	
1.2	Support parents and children to maintain a healthy weight	Number of attendances at Breastfeeding Peer Mentoring projects	PS Breastfeeding	New measure for 2016-2017	600	**226**	**126**	**Green**	
1.3	Increase interaction between parents and children, including healthy lifestyles and active play	Attendances at Health Promotion Projects run with Childrens Centres	KCC Children's Centres	New measure for 2016-2017	90	**36**	**0**	**Yellow**	No events have been run this quarter
1.4	Create new opportunities to build physical activity into daily lives	No. of participants attending activity classes funded through external funding bids	SDC Leisure Team, Sencio Community Leisure	1766	250	**93**	**36**	**Green**	
2	**Support older people to keep them safe, independent and living fulfilled lives**								
2.1	Develop Dementia Friendly Communities, improve early diagnosis of dementia and provide services and activities to support people living with Dementia	No. of attendances at Dementia cafes in the North of the District	- Alzheimer Dementia Support Services - Alzheimers Society Kent and Medway	476	500	**345**	**336**	**Green**	
2.2	Develop Dementia Friendly Communities, improve early diagnosis of dementia and provide services and activities to support sufferers and carers	No. of Dementia events held in libraries	KCC Libraries	2	4	**0**	**4**	**Green**	Pictures to Share' events held in libraries
2.3	Partnership working to promote and develop self help services	No. of people accessing Home Library Services	KCC Libraries	378	300 (avg)	**190**	**346 (avg)**	**Green**	
2.4	Increase referrals for home adaptations and falls prevention pathways to reduce the risk of falls	No. of attendances at Yoga, Chair Based exercise and postural stability classes	SDC Healthy Living Team	3500	3200	**989**	**830**	**Green**	This measure does not include Swanley Falls Attendance, which is not in at time of writing (18/10/2016)
2.5	Support older people and vulnerable people to remain in their own homes and live independently	No. of people accessing Care Navigator Service	West Kent Housing	298	300	**80**	**127**	**Green**	

Ref. No.	Target	How is that measured?	Lead	15/16 Baseline	16/17 Target	16/17 Q1	16/17 Q2	Year DOT	Notes
3	**Support businesses to have healthy workplaces**								
3.1	Support Kent Healthy Businesses Award	No. of Businesses signing a declaration of intent to take part in the National Healthy Businesses Award	SDC	2	10	**1**	**3**	**Green**	SDC are working with 3 businesses, although none have formally been assessed.. EH continues to advertise the programme through environmental permit visits in the future
	Support Kent Healthy Businesses Award	No. of Businesses achieving the National Healthy Businesses Award	SDC	0	1	**0**	**0**	**Yellow**	
4	**Meet the housing needs of people living in the District including affordable and appropriate housing**								
4.1	Carry out an Older Persons Housing Needs Assessment to better understand the needs of older people	No. of people consulted about the Strategic Housing Market Assessment (SHMA)	SDC Housing	SHMA Completed	OPHNA successfully tendered			**Green**	This action is currently on target and being completed by consultants
4.2	Provide affordable housing to meet identified needs of vulnerable groups	No. of affordable units developed	SDC Housing	9	70	**20**	**8**	**Green**	The number of new affordable homes is on target at the expected rate of delivery.
4.3	Work with developers, landlords and owner occupiers to provide adaptations to properties	No. of Disabled Facilities Grants approvedand installed	SDC Housing	120	80	**24**	**36**	**Green**	An additional 30 referrals came in through InShape this quarter. A part time Occupational Therapist is now employed to boost this further. A landlord event will be taking place on the 17th Oct.
5	**Sustain and support safe communities**								
5.1	Improve Road Safety	No. of speed watch enforcement operations taking place by trained volunteers	SDC CSU	New for 2016	10	**1**	**10**	**Green**	
5.2	Tackling Crime and ASB	All Victim Based crime Reduced compared to the previous year	SDC CSU	5548	<5548	**1334**	**2774**	**Green**	This is an increase of 7% on on the same time period last year, but is still on target for the number of crimes in the first six months of the plan (2774 crimes in the first 6 months)
6	**Reduce the gap in health inequalities across the social gradient**								
6.1	Reduce the prevalence of smoking, particularly in areas of deprivation	No. of people attending weekly Stop Smoking surgeries at Sevenoaks Library	KCC Libraries	New for 15/16	60	**26**	**11**	**Green**	
6.2	Reduce the prevalence of Type 2 diabetes through early detention and prevention	No. of attendances at Why Weight	SDC Healthy Living Team	1072	1000	**398**	**65**	**Green**	
6.3	Deliver activities to promote the benefits of increased physical activity and reduce obesity	No. of people attending SDC Health Walks	SDC Healthy Living Team	6849	7000	**1847**	**1572**	**Green**	This figure does not include Sevenoaks or Otford
	Deliver activities to promote the benefits of increased physical activity and reduce obesity	Usage figures for Sencio Centres/Facilities	Sencio Community Leisure	908015	908015 (+/- 10%)	**231091**	**214262**	**Green**	
	Deliver activities to promote the benefits of increased physical activity and reduce obesity	No. of Attendances at KAES Exercise Classes (All ages)	Kent Adult Education	806	300	**329**	**96**	**Green**	
	Deliver activities to promote the benefits of increased physical activity and reduce obesity	No. of GP or health professional referred clients	Sevenoaks District Council	New for 16/17	110	**21**	**9**	**Green**	
6.4	Deliver disability inclusive fitness activities	No. of attendances at dance and exercise classes at Mencap Hall	Mencap	12	12	**12**	**10**	**Green**	
	Deliver disability inclusive fitness activities	No. of Sevenoaks District residents benefiting from MIND fitness activities	West Kent Mind	1250	915	**0**		**Data Missing**	Awaiting data expected 12 Dec

Stan keeps his feet on the ground

A Swanley resident with a passion for plants is continuing to stay fit and active in the garden thanks to our Falls Prevention Classes.

In Shape spoke with 82 year old Stan Long, a former landscape management professional and keen gardener.

Stan, who has lived in the town for more than 40 years, attends our Falls Prevention Classes that have helped more than 50 older people over the last year to stay safe, active and independent by staying on their own two feet.

Stan says: "Although I've not had a fall, in recent years I had become more and more concerned that I may have one. I was quite worried that if I started to lean forward, even a little, I would lose my balance, stumble and end up on the floor. I know that at my age this can have serious, even life-threatening consequences.

"But when I heard about the Council's Falls Prevention Classes I thought it may help so I decided to give it a go.

"The classes are all about building up your body strength with simple exercises, improving balance and using tactics to help you stay on your feet in a no pressure, supportive environment. Best of all you're encouraged to go at your own pace.

"You start with a few seat-based exercises then you stand up to do a few gentle exercises to build up your leg muscles. Later there are further gentle exercises to improve your upper body strength by building up the muscles in your arms and shoulders.

"Improving your balance is obviously important, so part of the course is spent walking on your toes and your heels.

"But crucially it's the tactics taught throughout the course which really help. One of the things you're told is how to gradually stand up from

a seated position, reducing your risk of falling.

"If the worst happens, and you do fall over, you are taught how to get back on your feet without panicking using various positions that minimise the risk of further injury.

"Thanks to the course I am much more confident on my feet and I really believe that I can continue to stay active for longer. My wife Pauline is very pleased as well. She has seen my confidence grow since I took part in the Council's Falls Prevention Classes giving us more opportunities to spend time together in our garden."

To find out about classes near you, visit www.sevenoaks.gov.uk/falls or call us on 01732 227000.

How the waist was won

Hartley resident Maris Goddard is looking great since she took part in our 'Why Weight' health programme in September.

The 53 year old Bexley Council worker has lost a staggering three stone and, for the first time ever, even enjoys shopping for ladies' fashion. What's more her healthy habits have rubbed off on her husband who has lost weight as well.

Maris spoke with In Shape about Why Weight and how it's changed her family's life for the better.

"I heard about Why Weight from my GP. I have Type 2 Diabetes and was at the limit of taking oral medication to control my condition. My GP gave me an ultimatum: lose weight to reduce my blood glucose level or begin insulin injections.

"I decided to join the Why Weight 12 week healthy weight programme. Every week we started with 30 minutes of exercise. Combined with weekly weigh ins and advice about healthy eating and a healthy lifestyle, it gave me all the tools I needed to lose weight."

"Prior to Why Weight I'd refused to have scales at home, but I found it helpful to have someone keeping an eye on me during the weight ins, offering encouragement. The best thing was meeting up with likeminded people to share tips, experience, encouragement and plenty of laughs."

"Since finishing Why Weight, I take daily exercise and follow a healthy diet. For the first time in years I'm in control of my weight. I feel confident and even enjoy clothes shopping, something I've never done before."

"As well as losing three stone, my blood glucose level has reduced and I'm on track to reduce my medication. And, as my husband Colin eats the same as me, he too has lost two stone and is looking great! Now I weigh less than I did when we were married in 1981.

"I even have bathroom scales at home and look forward to weighing myself each week!"

The next Why Weight courses will begin on these dates and locations across the District.

- **Tuesday 22 April**, 6pm to 7.30pm, Sevenoaks Primary School
- **Thursday 24 April**, 1pm to 2.30pm, Swanley White Oak Leisure Centre
- **Monday 12 May**, 6pm to 7.30pm, Edenbridge Leisure Centre
- **Wednesday 2 July**, 6pm to 7.30pm, Swanley White Oak Leisure Centre
- **Friday 4 July**, 9.30am to 11am, West Kingsdown Community Centre
- **Friday 4 July**, 12 noon to 1.30pm, Sevenoaks Leisure Centre
- **Monday 22 September**, 6pm to 7.30pm, Edenbridge Leisure Centre
- **Tuesday 23 September**, 6pm to 7.30pm, Sevenoaks Primary School
- **Thursday 25 September**, 1pm to 2.30pm, Swanley White Oak Leisure Centre

To book a place, please call us on 01732 227000 or e-mail healthyliving@sevenoaks.gov.uk

Why Weight is run by Sevenoaks District Council and funded by Kent Public Health

'Yoganna' enjoy our flexible fitness classes

Yoga originated in India around 5,000 years ago and focuses on strength, flexibility and breathing and, according to one Sevenoaks District resident, can help change your life.

This ancient form of exercise has become commonplace across the world and classes can be found in leisure centres, hospitals, community centres and many more places.

Sonja Ellis attends our over 50s class every week in Dunton Green Village Hall.

The classes, which are led by yoga expert Sabine Smith and run by Sevenoaks District Council, offer a friendly environment with gentle yoga and relaxation techniques.

Retired Sonja, who lives in Park Lane, Kemsing, says: "I have some joint problems and was told by various doctors to try out yoga and, as soon as I did, it changed my life!

"It's helped to reduce my pain and discomfort by half and if I don't go to a class I can really feel the difference. It's kept me going mentally, is relaxing and makes me feel really good afterwards."

The NHS says that yoga is a safe and effective way to increase physical activity, especially strength, flexibility and balance. It also says there's some evidence that regular yoga practice is beneficial for people with high blood pressure, heart disease, aches and pains – including lower back pain – depression and stress.

Sonja has been attending one of Sabine's yoga classes for around six years, having started the classes after moving to Kemsing from Cornwall.

She adds: "Attending the class has just given me another outlook. I've even opened a B&B, which is something I would not have done before!

"Sabine is a fantastic teacher and very diligent, watchful and mindful

when dealing with older people. We always have a laugh and I've made some like-minded friends as well."

There are three classes held every week, with one of the classes offering informal chats on lifestyle information led by guest speakers. All abilities are welcome and there is no need to book, you can just turn up and enjoy the class!

For more information visit www.sevenoaks.gov.uk/yoga

Your local yoga classes

- **Dunton Green Village Hall** – Wednesdays 3pm to 4.30pm – £2.50 per person
- **Shoreham Village Hall** – Wednesdays 1pm to 2pm – £2 per person
- **South Downs Retirement Village** – Tuesdays 10.30am to 11.30am – £2 per person

The over 50s yoga classes are funded by Kent Public Health.

sdc_newsdesk

sevenoaksdc

A café with a difference!

Dementia affects not only those living with this life changing condition, it all too often has a profound affect on close family and carers.

But a new 'memory café' has started up in West Kingsdown offering support to both groups.

Alzheimer's & Dementia Support Services opened the doors to its latest café in Kingswood Court and, unlike most cafés, tea, coffee, cake and biscuits are free!

Rosa Mullis, Service Co-ordinator at Alzheimer's & Dementia Support Services, told In Shape how the latest memory café came about and how it's helping locals.

"The suggestion of a new memory café came from Jackie West, West Kingsdown's Community Warden. She felt there was a need for this facility as there is a growing number of people living with dementia in the area so we took up the idea. We always try to respond to local need and rely on people like Jackie to help us identify where our services would be best offered.

"We opened on 5 May offering a friendly, supportive and relaxed environment for people living with dementia and their carers.

"When you live with dementia your short term memory is often the first to be affected. Older memories can become clearer and more important so we spend time at the cafe reminiscing, chatting and sharing memories.

"But we find carers can often become isolated. The café gives them the chance to talk with other carers and take a well earned break as one of our trained volunteers supports their loved ones.

"We also provide information about living with dementia, services available locally and regularly invite guest speakers. It could be the Fire Service covering fire safety or a visit by nurses from our local memory clinic. We have even run gentle exercise classes.

"New people are always welcome and our volunteers will greet people at the door and ensure that they receive a warm welcome."

Your local Memory Cafés

Swanley Memory Café*
White Oak Court Sheltered Housing Unit, Sycamore Drive, Swanley, BR8 7WF
2pm to 4pm on the second Friday of each month

Hartley Memory Café*
Wellfield Community Hall, DA3 7EG
10am to 12 noon on the first Thursday of the month

West Kingsdown Memory Café*
Kingswood Court, 65 Church Road, West Kingsdown, TN15 6LN
10am to 12pm on the first Tuesday of the month

Sevenoaks Dementia Café**
The Stag Theatre, London Road, Sevenoaks, TN13 1ZZ
2pm to 4pm on the first and third Tuesday of the month

* For information about these cafés please call Alzheimer's and Dementia Support services on 01474 533990

** For information about this café please call the Alzheimer's Society on 01892 559410

Agenda Item 7

To: **West Kent Health and Wellbeing Board**

Report Authors: **Jane Heeley, Chief Environmental Health Officer**
Heidi Ward, Health Improvement Manager

Date: **20th December 2016**

Subject: **Health Inequalities Action Plan Update – Tonbridge & Malling**

Summary

This report aims to provide the West Kent Health and Wellbeing Board with an outline of local activity relating to health inequalities and an update on progress against the Tonbridge & Malling Health Inequalities Action Plan (2013 to 2016).

Recommendations

The Board is asked to note the content of the report and our monitoring data in Annex 1and advise how Board Members would like to be involved in the development of our new Plan, which will be launched next year.

1. Background

1.1 Both the Tonbridge & Malling Health Action Team (HAT) and Health Improvement Officer Study Group (HIOSG) have as one of their key aims the reduction of health inequalities. In the case of the HAT we aim to bring health partners working in the district together and membership consists of representation from both the wider health and housing sectors, including a number of voluntary sector members. The HI OSG is attended by representatives from a number of frontline Council services, to collectively review ways of working that will both improve the health of our residents in general and reduce health inequalities.

1.2 The health of people in Tonbridge & Malling is generally better than the England and Kent average. However, some significant differences in life expectancy exist between our communities. By exploring more detailed data at borough, ward and lower super output area level and utilising our existing knowledge of our communities we have been able to set five priorities in partnership with our key stakeholders; demonstrating a holistic approach to tackling health inequalities.

These are outlined below:

- Unhealthy weight in children and adults
- Falls prevention
- Dementia awareness
- Alcohol and substance misuse
- Smoking related deaths

2. Mind the Gap Health Inequalities Plan

2.1. In June 2013 the Tonbridge & Mallling Health Inequalities Action Plan 2013 to 2016 was presented to and approved by Members at the Communities and Health Advisory Board. This plan is underpinned by KCC's Joint Strategic Needs Assessment for Kent and supports the outcomes and priorities set out in KCC's Kent Joint Health and Wellbeing Strategy (2014-17) and the Children and Young People Health and Wellbeing Strategy.

2.2. The actions and priorities identified in our 'Health Inequalities Action Plan' can be categorised into Marmot's (2010) six Life-course Objectives, in line with the Kent Plan:

- Give every child the best start in life (Conception – 9 months and from 9 months)
- 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 a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health

Each of our Services have identified how their work can contribute to the Plan and reducing local health inequalities and these are reflected in Annex 1.

3. Progress

3.1 Since the Plan was adopted in 2013 significant progress has been made through the HIOSG in bringing Services together to deliver health improvement. In particular developing an understanding of "Place Based Health" across our services and how our work that contributes to the development of this model.

3.2 In respect of the main HAT priorities there have been improvements in the rates of obesity in children in year 6 and a slight improvement in the rates of hip fractures in over 65's. Excess weight and obesity rates in adults have remained similar, as has the rates of hospital stays for alcohol related harm and smoking

related deaths. There has been an increase in alcohol related hospital admission rates for under 18's.

4. Future Working Arrangements

4.1. The position regarding devolution has been outlined in detail in the Tunbridge Wells report, the Tonbridge & Malling are part of this cluster, along with KCC, Sevenoaks and Tunbridge Wells. Consistent with the view expressed by the Tunbridge Wells report authors we envisage that these proposals will have a positive impact on the delivery of health improvement and focus around the wider determinants of health.

4.2. A new Health Inequalities Action Plan will be produced in 2017 to run until 2020, this will again reflect our local priorities and link with the KCC Plan.

5. Conclusion

5.1 The Health Inequalities Action Plan provides a focus for the work undertaken by the Council and its partners to tackle the health inequalities in our communities. It is hoped that this will be further developed through the new Plan and that the good work that has begun to integrate across this area can be built on to achieve strong local outcomes.

103

West Kent Health Inequalities Action Plan Progress Report – December 2016 Agenda Item 7

2013/16 - April 2013 – March 2016

OBJECTIVES	DETAIL	LOCALITIES
		Tonbridge & Malling
Objective 1: **Give every child the best start in life**	**Local Priority:**	**Promote health in pregnancy and the new born and support parents so that they can raise emotionally and mentally healthy children. Promote healthy weight for children & young people.**
	Actions:	• Increase breastfeeding prevalence 6-8 weeks & promotion of 'smoke free' homes. • Deliver Learn Eat & Play - LEAP family weight management programme in target schools • Improve housing conditions where the child's home is not meeting the minimum standard. • Support mothers experiencing domestic abuse through a commissioned service (DAVSS) • Support families with issues of mental health.
	Progress:	• Promotion of 'Smoke Free' homes in partnership with KFRS. • Worked with partners and breast Buddy Volunteer to raise awareness in the importance of breast feeding. • Community/schools events regularly attended in priority area/schools/children's centres. • Development of Learn, Eat & Play - LEAP family weight programme and increase in 1:1 delivered in schools for more complex families from more deprived areas. Referrals through Early Help/School nurses with increase in families referred under Social Services • Attendance at quarterly child healthy weight meetings to work with School nurses and child health teams & partners to support healthy weight in children (6 target schools) and children identified through the National Child Measurement Programmes • Housing team working with health team to support families living in poor housing conditions. • TMBC Health Team & Community Safety Partnership has commissioned DAVSS (Domestic Abuse Volunteer Support Service) and Choices to provide support for victims of domestic abuse. DAVSS provide support for our standard/medium risk victims and Choices provide support for high risk victims. • Deliver Mental Health programmes in schools and a mental health programme in the community for parents.
	Outcomes:	**Community events** 10 community events per annum attended supporting good health and wellbeing for families (including smokefree homes, family nutrition and breastfeeding awareness)

OBJECTIVES	DETAIL	LOCALITIES
		Tonbridge & Malling
		Family Weight Management **Over 3 years** **20** LEAP programmes delivered **150** families over 3 years. **196** Children engaged 3 years **6 school** events attended **per annum** including community chef and nutrition and physical activity sessions **2015/16** • **6 LEAP** programmes delivered • **Seven 1:1** sessions were completed • **35** families with 45 children engaged • **29** families with 38 children completed • **35** families engaged from target schools • **17** children engaged with the programme above the **95th Centiles.** • **17** children reduced or maintained their BMI score • **16** completers (over 91st Centile) reported an improvement in their diet • **16** completers (above 91st Centile) reported an improvement in their physical activity levels. • **20** children improved their waist measurement **Housing** New 'Health' & 'Housing' newsletter created to promote healthy living to families New Health Improvement GP referral form created to include housing and finance **Domestic Abuse** **Two** training events held **118** victims Supported through DAVSS (April 2015 to date) **116**Referrals to Independent Domestic Violence Advisor (IDVA) (April 2015 to date) **Mental Health** Schools –**SAFE (Suicide Awareness for Everyone)** Delivered in 6 schools(2013/15) and Mental Health In School

OBJECTIVES	DETAIL	LOCALITIES Tonbridge & Malling
		project delivered in 4 schools (2014/15) Parents - 4 **Jasmine** Programmes delivered per annum (11 over 3 years) – low level mental health issues **Leisure** • 854 places booked on Summer Playscheme with 270 Leisure Pass bookings. 590 places booked on Holiday activities with 113 Leisure pass bookings. 143 spaces taken for Y2Crew activities 54 Leisure pass rates • Approximately 700 Excel members (11-18 year olds) and approximately 350 Kickstart members (0-10 years old) • Young leaders in cricket courses undertaken covering Tonbridge and Malling areas with presentation at Lords Cricket ground, attracted 10 young cricketers aged 14 to 16 years, skills gained in leadership, first aid, officiating, groundsmanship.
Objective 2: Enable all children, young people and adults to maximise their capabilities and have control over their lives	**Local Priority:**	**Reduce risk taking behaviours in young people and support people to live safe, independent and fulfilled lives.**
	Action:	**Young People (YP)** • Tackle harmful effects of alcohol • Denormalise attitudes to alcohol and halt uptake of smoking in YP • Empower YP to have a voice on health related issues • Support children with special educational needs and/or physical disabilities to lead a healthier life **Older People** • Support older people to lead healthy lives. • Support the joined up delivery of effective falls prevention work • Improve housing conditions where the home is not meeting the minimum standard for housing. • Support the Tonbridge and Malling Seniors Forum in their role in highlighting issues of health to older people in Tonbridge & Malling
	Progress:	• The CSP commissions the Kenward Trust to provide outreach work for young people who may be at risk of drug and/or alcohol misuse • Identified areas where children/young people (YP) drink & introduce initiatives to reduce risk (Kenward Trust)

OBJECTIVES	DETAIL	LOCALITIES Tonbridge & Malling
		• Smoking advice given to YP through schools/colleges initiatives. • Snodland Community Alcohol Programme (CAP) has been running since 2012 and brought together a wide range of local agencies to tackle the issues of both youth and adult alcohol consumption and related anti-social behaviour. • Leaflets around proxy purchasing (adults buying alcohol for underage young people) distributed to warn them that they risk a fine if they do this. • An article around the CAP appeared in the Holmesdale School newsletter & Kenward Trust have been engaging with young people in the area, attending the Snodland Carnival and the Christmas in Snodland event. • Delivered a range of diversionary activities through the Y2 Crew scheme to support vulnerable young people make healthy choices. • Tonbridge and Malling Youth Forum supporting young people to get involved with and have a say on the services provided and required within their communities. • Discovery day event to support children with special educational needs and/or physical disabilities to lead healthy lives • Tonbridge and Malling Youth Forum had 5 meetings in 2016. • 70 children aged 8 to 14 years with wide range of learning difficulties attended Discovery Day (dedicated event with organised sport/ craft and activity session) **Older People** • Housing - overcrowding identified and advice/solutions to remove hazards as assessed • TMBC housing team to work with housing provider on Disabled Facilities Grant (DFG) work to fund adaptations for their tenants and in partnership with CCG/KCC to ensure funding is spent appropriately and in a joined up way. • All properties going through the rent deposit scheme Inspected • Health & Housing Newsletter created and sent out quarterly & attendance at strategic health meetings. • Households assisted with Falls prevention assistance • Work with Seniors Forum to raise health issues for older people
	Outcomes:	**Young People** **Alcohol** Over 6 areas per annum identified where YP drink & Kenward Trust set up initiatives to support YP

OBJECTIVES	DETAIL	LOCALITIES
		Tonbridge & Malling
		April to September 2016 - Malling School – talk to Year 10 (60 pupils) - Group of 11 who came to Kenward. - Outreach work in East and West Malling – interacting with a group of 15 young people off and on in the two areas - Tonbridge Lock – engaged with over 60 young people and adults spoken to about safety and other substance related issues. - Snodland - a small group of 9 males aged 15 to 19. - Snodland youth club run by the church they delivered some education to a group mainly younger members of the community aged 11 to 13. - Tonbridge Race Park and high street the number averaged in groups of 5 to 40+ mainly at the school footfall time. - Tonbridge grammar school - Year 10 alcohol talk to 70 young people Attended 'Safety in Action' event and engaged with 630 primary school pupils. **Smoking** 9 secondary school events attended promoting stop smoking and healthy living over 3 years. **Empower YP** 5 Youth Forum meetings held per annum There were 143 spaces taken for Y2Crew activities over the summer holidays as well as drop in sessions. 70 children aged 8 to 14 years with wide range of learning difficulties attended Discovery Day (dedicated event with organised sport/ craft and activity session) **Older People** **Seniors Forum** Attendance at **two** of Tracey Crouch MP Older Peoples Health Fair Attendance at **3** Senior Forum events and 4 healthy lifestyle/nutrition presentations given to forum. Supporting older people onto weight management programmes through more accessible venues and offering appropriate physical activity sessions such as 'chair based exercise' shorter 'health walks'
Objective 3:	**Local**	**Support Businesses to have healthy workplaces and increase employment for disadvantaged people and education for young people.**

OBJECTIVES	DETAIL	LOCALITIES Tonbridge & Malling
Create fair employment & good work for all	**Priority:**	
	Action:	• Work with businesses through the KHBA & reduce smoking around routine manual workers • Increase employment opportunities • Promote apprenticeships for YP
	Progress:	• Businesses signed up to KHBA and working towards awards • Implement employment policies and adopt Local Development Framework • Through the West Kent Partnership and Careers and Enterprise Company it is agreed TMBC will contribute to an enterprise network advisor next financial year covering West Kent schools (tbc in January 2017).
	Outcomes:	**Businesses** Since April 1015, 21 TMBC have worked with 21 Businesses with 17 signed up to working towards the award **Employment opportunities** New Employment Land Review Promotion of Better Business For All BBFA, Estates Excellence and KHBA to businesses West Kent Jobs and Training Fairs in partnership with JobCentre Plus (1 delivered per annum) Annual West Kent SkillsFest event in partnership with Education Business Partnership Kent. **Young People** 3 apprentices appointed per annum (9)
Objective 4: Ensure healthy standards of living for all	**Local Priority:**	**Support financial capacity and inclusion and support families in poverty**
	Action:	• Enable people to access affordable credit • Check affordability of all tenancies helped through Rent Deposit Scheme • Improve Housing Conditions where not meeting minimum standard • Promote Energy efficiency to increase warmth & reduce fuel poverty • Promote Leisure Pass Scheme
	Progress:	• Increased awareness of credit Unit • Citizens advice funded to provide advice on debt/benefit advice

OBJECTIVES	DETAIL	LOCALITIES Tonbridge & Malling
		• All new tenancies supported via rent deposit Scheme to ensure rent is affordable • All referrals for housing conditions visited within 10 days • Energy Company Obligation – Affordable Warmth Programme and Rural Homes initiative
	Outcomes:	• Leisure Pass promoted through all communication channels
Objective 5: Create & develop healthy sustainable places & communities	**Local Priority:**	**Reduce Homelessness and fuel poverty and develop healthy /Safe Communities**
	Action:	• Support people in the borough to prevent homelessness • Provide free access to outdoor Leisure facilities & develop greenspaces • Improve air quality & noise pollution • Reduce impact of poor housing • Promote Community Safety Unit/Kent police initiatives • Advice and financial assistance to fund affordable warmth
	Progress:	**Housing** • enhance housing options service, work with private sector housing • Warm Home Assistance • West Kent Joint Homelessness strategy **Outdoor Leisure** Maintain & improve quantity, quality, & accessibility to greenspace
	Outcomes:	**Leisure** • Open Space Strategy developed • 100% councils outdoor playgrounds and open spaces including Hayesden and Leybourne Lakes Country Parks provided free • Over 10 events held at our country parks • Play area enhancement at Haysden Country Park • Educational interpretation enhancement at Leybourne Lakes Country Park • Play sculptures at LLCP

OBJECTIVES	DETAIL	LOCALITIES
		Tonbridge & Malling
		• Park runs at LLCP and at TRS • Junior park run being investigated
Objective 6: Strengthen the role and impact of ill health prevention	**Local Priority:**	**Reduce the gap in health inequalities across the social gradient, including access to screening, mental health services & partnership / community work**
	Action:	• Ensure health improvement services are targeted appropriately • NHS Health Checks in workplaces& community settings • Deliver Tier 2 Adult weight management programme in community settings & Health walks • Deliver Brief advice on alcohol • Deliver 'Jasmine' in communities, training for frontline staff and promotion 6 ways to wellbeing. • Continue with 'virtual healthy living model' and partnership work through strategic meetings • Appropriate training/competence/quality of staff.
	Progress:	Weight Management Programme delivered in priority areas and demographic/equality data collected, • Trench Baptist Church, • East Malling Centre, • Snodland Community Centre • Wateringbury GP practice, • Borough Green GP Practice, • MIND Tonbridge Centre (mental health group & Nepalese group), • Larkfield and Angel Leisure Centre. NHS Health Checks delivered in libraries, workplaces and community events emphasis on routine manual workers and key priority areas; Snodland, East Malling, Trench. All eligible weight management clients offered check.
	Outcomes:	**Health Checks** **579** Health Checks **(3 years)** **187 (3 years)** Wellbeing Checks (health check without cholesterol testing) Over 30 Businesses engaged with Healthy Business Award and offered health checks **Adult Weight management** Over 3 years;

OBJECTIVES	DETAIL	LOCALITIES
		Tonbridge & Malling
		70 Group programmes **23** 1:1s **700** engagers **2015/16** **27** Counterweight programmes run **Eight 1:1** sessions were completed **278** people engaged **217** people completed the programme **101** engagers (completers) achieved 3% weight loss at 12 weeks **200** completers lost some weight during the programme **43** completers achieved 5%+ weight loss at 12 weeks Average weight loss for the programme was **3.3% over 12 weeks.** **150** engagers reported a higher wellbeing score **132** engagers reported an improvement in their diet **161** engagers reported an improvement in their physical activity levels. **Alcohol Brief advice** – **1300** over 3 years (Target of 250 per annum) – through weight management, community events, Health checks. **Brief Advice on Smoking** – **1300** people asked whether they smoke, **60** of identified smokers referred. **Health Walks** **5** new health walks set up in areas of deprivation and **2** GP practices. Walk length changed to shorter walks aimed at getting inactive people active. Total of **680 walkers** registered on database **Mental Health** **3** Jasmine programmes delivered annually (9 over 3 years) a total of 125 signed up 80 engaged. Complemented with nutrition & weight advice & health walks. 2 World Mental Health Day events organised with MIND Charity. **Partnership work**

OBJECTIVES	DETAIL	LOCALITIES
		Tonbridge & Malling
		Developed Health Action Team meeting to include reps from CCG 36 community partnership events attended over 3 years. **Training** 1 UK Public Health Registered staff, 3 Public Health Champions, 4 MECC trained online, Mental health awareness, Suicide prevention training, Brief advice on alcohol & smoking, Safeguarding, Dementia Friendly Training.

Agenda Item 7

To: **West Kent Health and Wellbeing Board**

Report Authors: **Cllr Lynne Weatherly, Portfolio Holder for Communities and Health**
Gary Stevenson, Head of Environment and Street Scene

Date: **20th December 2016**

Subject: **Health Inequalities Action Plan Update - Tunbridge Wells**

Summary

This report aims to provide the West Kent Health and Wellbeing Board with an outline of local activity relating to health inequalities and an update on progress against the Tunbridge Wells Health Inequalities Action Plan

Recommendations

The Board is recommended to:

i. Consider and comment on the content of the report and the local structure relating to health inequalities

ii. Consider and comment on the progress against the Health Inequalities Action Plan

iii. Explore opportunities to work alongside and support the Health Action Team for the remaining lifespan of the Action Plan.

1. Background -Tunbridge Wells Health Action Team

1.1. The Tunbridge Wells Health Action Team is a long standing partnership group committed to tacking health inequalities in the borough. The meeting is chaired by the portfolio holder for Communities and Health, Cllr Lynne Weatherly and meets quarterly.

1.2. The stated aims of the group are: a) supporting the wider workforce to understand the causes of Health Inequalities and how the work that we undertake and the decisions we make can have a positive or negative influence on Health Inequalities and b) working in partnership to facilitate a reduction in Health Inequalities in Tunbridge Wells Borough.

1.3. The stated purpose of the group is: a) to act as a forum that enables two-way communication with the West Kent Health and Wellbeing Board b) to develop,

monitor and review an Action Plan to reduce Health Inequalities in Tunbridge Wells.

2. Mind the Gap Health Inequalities Plan

2.1. In the Summer of 2015, Tunbridge Wells Borough Council, in partnership with the Health Action Team, published the Tunbridge Wells Borough 'Mind the Gap' Health Inequalities Action Plan 2015-2019

2.2. The Tunbridge Wells Mind The Gap Plan is underpinned by KCC's Joint Strategic Needs Assessment for Kent and supports the outcomes and priorities set out in KCC's Kent Joint Health and Wellbeing Strategy (2014-17) and the Children and Young People Health and Wellbeing Strategy.

3. Local priorities

3.1. The actions and priorities identified in our 'Mind The Gap Plan' can be categorised into Marmot's (2010) six Life-course Objectives, in line with the Kent Plan.

- Give every child the best start in life (Conception – 9 months and from 9 months)
- 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 a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health

3.2. The health of people in Tunbridge Wells is generally better than the England and Kent average. However, differences do exist between our communities. By exploring more detailed data at borough, ward and lower super output area level and utilising our existing knowledge of our communities we have been able to set six priorities in partnership with our key stakeholders; demonstrating a holistic approach to tackling health inequalities. These are outlined below:

- Self Harm
- Excess Winter Deaths
- Falls Prevention
- Adult and Child Obesity
- Smoking related deaths
- Alcohol Misuse

In addition, we will also make a commitment to improving geographic Access to Services, particularly in rural areas through the HAT partnership.

4. Progress

4.1. Progress against the priorities is measured using the Public Health England Health profiles (updated annually). An update report on progress was taken to the September Health Action Team and to the November Local Children's Partnership group.

4.2. In addition, partners in the Health Action Team provide regular updates on the activity they have been undertaking which contribute towards the plan and the ambitions.

4.3. The year one update is attached. The first table covers progress against priorities, the second offers an update on activities by Health Action Team partners.

4.4. Regarding the priorities we have seen:

- An increase in the rate of hospital stays for self harm
- A decrease in the number of excess winter deaths
- A decrease in the rate of falls but an increase in the number of hip fractures
- There was a decrease in the percentage of children who are obese at year 6
- A slight decrease in the rate of smoking related deaths
- An increase in the number of hospital stays for alcohol related harm

4.5. At the Health Action Team meeting in September 2016 a number of actions were agreed, including a joint discussion with Kent Public Health, the CCG and the Community Safety unit, specifically looking at self harm and alcohol related harm. A date is currently being sought. In addition, the Healthy Lifestyles Co-ordinator (maternity cover) is now attending the West Kent Health and Wellbeing Board Alcohol subgroup.

5. Devolution

5.1. Kent County Council has a statutory duty to deliver the Public Health function, in partnership with others, to improve the health and wellbeing of Kent residents and reduce health inequalities. All Councils have a duty to plan for the health and wellbeing of the residents they serve. District and Borough Councils have a role to play in delivering health protection, health improvement and key services to address the wider determinants of health.

5.2. The 2015 King's Fund report 'The District Council Contribution to Public Health: a time of challenge and opportunity' looked at the opportunities for District and County Councils to work together holistically to deliver the public health agenda. The report demonstrates that 'district councils are in a good position to influence

many factors of good health through their key functions' and describes a 'radical upgrade in prevention'. The County Council's new countywide preventative service strategy is to offer seamless support to individuals who need to make change lifestyle changes to improve their health, to help motivate this change, to support making the change and then maintain it so that it becomes a new norm to their lifestyle.

5.3. The proposed West Kent Health Improvement Model is informed by the King's Fund report and the West Kent Health Deal. The model provides for the four councils to manage their collective resources in a way that not only generates best value for money and delivers against outcomes but also provides a platform for further integrated working that delivers longer-term health improvements.

5.4. District and Borough Councils will, through a local hub model, play a full role in the co-ordination and delivery of the local public health (preventative services) provision, ensuring that services address local needs and are co-ordinated with other local delivery.

5.5. It is envisaged that there should be one single referral point for the three Districts that feeds into a local arrangement for each district or borough that enables a holistic assessment of individual needs and considers the wider determinants of health such as debt, employment and housing conditions. Co-location of locally procured services within the District and Borough Council offices will enable the integration of this new assessment function and make for efficiencies in delivery and better outcomes for the customer

5.6. The District, Borough and County Councils would work together to bring the necessary range of skills and experience together to maximise health outcomes.

6. Impact on the Tunbridge Wells Mind the Gap Health Inequalities Action Plan

6.1. Should the above go ahead as outlined, it is likely there will be a positive impact on the Plan. As there will be a great emphasis on tailored support for service users, more focus on community based and community led activity and on the role of 'place shaping' for health, this will enable the Council to more effectively develop a healthy environment in which the health action plan can take effect.

6.2. Furthermore the plan is owned by the health action team rather than exclusively by the Council. Therefore the plan is not dependent on external funding and instead brings together combined effort. Although it is possible for example, that TWBC will no longer be running child weight management services, the Council and the Health Action Team will still consider this a priority for the borough and

therefore take a role in co-ordinating and overseeing the combined effort and response.

6.3. The Plan will run for another three years and will continue to be reported on annually by, and to, the Health Action Team.

7. Conclusion

7.1. The Health Action Plan provides a focus for the work undertaken by a wide range of organisations to tackle the health inequalities local residents experience. In this latest review we have seen mixed performance against our six local priorities, with five measures showing improvement and three declining.

7.2. We ask the West Kent Health and Wellbeing Board to note the contents of this report and to work with the Health Action Team on the remaining years of the Plan, and to work with the Council and partners as we move into the new phase of devolution for public health.

119

Priority	Marmot (2010) main policy objective	Baseline	2016 update report	Change from Baseline to current reporting	Primary Agency/Agencies
Self Harm - per 100,000	Objective: Reduce risk taking behaviours in young people (per 100,000)	217.6 (2014 Health Profile) Hospital stays for self harm, Per 100,000	263.3 Nov (2015 health profile) Hospital stays for self harm per 100,000	There has been an increase in the rate of hospital stays for self harm per 100,000 people. The Tunbridge wells rate is consistently higher than the England rate.	TWBC
Excess winter deaths	Objective: Reduce fuel poverty by supporting development of warm homes	77 (2014 Health Profile) This figure is the local number. The local value is 27.6. Excess winter deaths (three year)	61.3 Nov (2015 Health Profile) This figure is the local number. The local value is 21 (excess winter deaths (three years)	There has been a decrease in the number of excess winter deaths. The rate is now just below the England average, having been above it for four consecutive years	TWBC/KCC
Falls Prevention - Hospital admissions for falls per 100,000 population	Objective: Support older people to live safe, independent and fulfilled lives	845 Hospital admissions for falls per 100,000 population during 2013/14 (Older People Health & Social Health & Social care maps). 117 Hip fractures in people	810 Nov (Health and Social Care Maps) 127 Hip Fractures	There has been a decrease in the rate of falls There has been an increase in the number of hip fractures	West Kent CCG/ Good Neighbour

		aged 65+ (2014 Health Profile)	(2015 Health Profile)		
Child and Adult Obesity - Year 6 (age 11) (Obese)	Objectives: Promote healthy weight for children. Reduce the gap in health inequalities across the social gradient.	15.6% 2014 Health Profile	13.7% (2015 Health Profile)	There was a decrease in the percentage of children who are obese at year 6	TWBC Health Team/ Healthy Schools/ School Nurses
Smoking Related Deaths	Objective: Strengthen the role and impact of ill-health prevention	19.3% (227/ 100,000) 2014 Health Profile	224.8/100,000 (2015 Health Profile)	There was a slight decrease in the rate of smoking related deaths	KCHFT Stop Smoking Service
Alcohol Misuse - Hospital stays for alcohol related harm	Hospital stays for alcohol related harm Objective: Support safe communities	515 This figure is the local number. The local value is 470 (2014 Health Profile)	548 This is the local number. The local value is 498 (2015 Health Profile)	There was an increase in the number of hospital stays for alcohol related harm	Community Safety Unit

Priority 1 Self Harm

Action/Intervention	Measure	Latest Note
To support families in turning their lives around through targeted and intensive support of Families First	Support with key health and social issues affecting them	30 families have been worked with through the troubled families funding.
To provide timely and appropriate advice and support with issues and concerns that are affecting individuals through the Health Help Now App in West Kent	No. of site visits	The number of visits as at the end of May for the website for the county was **134,068** and for the app it was **9,374,** with 1286 allocated to the west Kent area.

Action/Intervention	Measure	Latest Note
To provide support for the issue of mental health (including self harm) in 4 schools (minimum), in areas of high need using a range of intervention methods including whole school approach, staff training, one-to-one and group work; supporting a reduction in emergency admissions for self harm in under 18s.	No. of Schools and individuals worked with. Improved emotional wellbeing, attendance, attainment and behaviour change among young people receiving a direct intervention. Referrals to partners such as Troubled Families and Child Adolescent Mental Health Services.	Currently working with Skinners Kent Academy, St Gregory's, St Matthews, Temple Grove Academy and Hawkhurst Primary. 12 young people supported on 1:1 sessions and 44 YP supported in group therapy. Completed pre and post intervention SDQs from 10 YP have indicated improvements in emotional symptoms, conduct problems, hyperactivity and therefore total difficulties following completion of sessions. An improvement in prosocial behaviour was also noted.
To increase awareness of youth suicide and mental health problems, through SAFE spaces, assemblies, PSHE lessons, training and signposting that will support a reduction in emergency admissions for self harm in adults and under 18s.	Increased awareness of youth suicide amongst YP Increased awareness of the danger signs of mental health difficulties among YP Increased awareness of the needs of YP with mental health issues among external professionals Captured by pre and post intervention analysis	Currently working with TWGGS and Skinners. End of year report available in April.
To offer safe support and advice to vulnerable people late at night.		Engaged: Q1 = 880 Q2 = 1105 Q3 = 899 Q4 = 731 Number of ambulances called: Q1 = 2 Q2 & 3 = 0 Q4 = 1 Police Call Outs: Q1 = 14 Q2 = 10 Q3 = 6 Q4 = 1
To provide weekly art therapy to those with mental health issues, learning disabilities, emotional and behavioural problems through 'Mindwell'	Improved social skills and co-ordination for participants	Regular 20+ attendees at the morning session taking place at Trinity Art Centre, group now being extended to afternoons taking place at Grosvenor and Hilbert Park Hub.
To provide help to people with mental health conditions through books on prescription, as wells the mental health benefits of reading for pleasure	No. of referrals	Deliver to 37 people though the home library service.
To deliver Mental Health First Aid training available free to all front line staff	No. of sessions held No. of attendances and variety of organisations represented Training evaluations	

Priority 2 & 3 Excess Winter Deaths & Falls Prevention

Action/Intervention	Measure	Latest Note
To provide disabled facilities grants to clients who require adaptions and equipment enabling them to maintain their independence, quality of life and live safely in their homes.	No. of grants issued	72 DFG grants given in 2015/16
To risk assess properties in line with the Housing Health and Safety Rating System (for hazards such as falls on stairs or in the bath), following a vulnerable person enquiry/ complaint, which leads to action (such as provision of handrails, bathing equipment or handyperson service).	500 handyperson jobs per annum People signposted to suitable support services	Handyperson numbers continue to be around 500 cases. These include aids and small repairs, key safes and bathing equipment.
To co-ordinate referrals from clients to social services, VCS and carers who will assist client to get repairs/ heating or insulation improvements done, for a more integrated approach	Quicker, more effective processing of improvements helping people stay in their home for longer	25 referrals for energy works
To deliver the care navigator scheme which supports people over 50 to access services including disabled adaptations, referrals, grants and benefits assessments.	No. of people supported, signposted and referred.	New Referrals received by quarter: Q1 = 97 Q2 = 122 Q3 = 93 Q4 = 153 149 people were supported over Q1 and Q2 and 292 people supported over Q3 and Q4.
To advocate for and provide support to people aged 65+ enabling them to take control over their care needs and decisions that affect them through more informed choices.	People are supported to stay in their own homes for longer	79 new referrals for befriending support and 25 existing clients supported during 15/16. 104 clients supported in total. 6915 volunteer hours
To improve postural stability and reduce the risk of falling (and related injuries) for people aged 65+ who are at risk or those with a long standing medical illness through strong and steady classes.	Risk of falling and injuries is reduced and people are able to stay in their own home for longer. No. of people supported	217 referrals to falls prevention during 15/16. 179 clients attending classes over this time, of which, 70% reported an improvement in confidence, strength and balance. Falls were reduced by 54%.
To develop services to assist people living with dementia and their carers through the 'Reading Well' books on prescription for dementia scheme and 'Home Library' delivery service	People more confident in understanding and living well with dementia	TW library has spoken to 59 people so far this year at the Dementia Cafes. We deliver to 37 people through our Home Library Service.
To raise public and professional awareness of	Which contributes towards the West Kent CCG's	WK dementia diagnosis rate is 59.5% (May 2016, Zena Watson

Action/Intervention	Measure	Latest Note
the experience and needs of people affected with dementia (and their carer networks) through training, dementia friends sessions, public events (dementia awareness week), cafes, outreach, carer support and information.	target to Improve dementia diagnosis rates from 51% to 67%	(zena.watson@nhs.net - WK CCG) Dementia Friends Training delivered to 12 people at TWBC offices on 21 June 2016. The Dementia Friendly Homes Project, funded through the innovation fund last year, has been successfully running with contact from West Kent CCG recently who will be integrating our project referral form into all the West Kent medical services. Gregg's Wood Medical Centre planting scheme completed by KHWP on 31 May 2016 following a reminiscence and plant selection workshops with Alzheimer's UK. Beds were constructed by volunteers at the local Men's Shed project.
To increase up take of Eco funding measures to provide warm insulated homes	No. of homes assisted	49 enquires but only 2 that have actually progressed. It requires top up funding which often people cannot afford to do. There is a lack of engagement from HCPs, who need to refer. Further promotion being undertaken to increase take up of the scheme.
To increase take up of warm homes bonus for vulnerable people (aged 65+ with a long term health condition).	No. of homes identified and assisted.	Promotion via local groups, flyer and Local magazine. Continue to work with landlords and raise awareness of this work.
To encourage, educate and enforce measures in rented properties to improve thermal efficiency	From 01/04/2018, it will be illegal to let properties when EPC lower than E.	Continue to work with landlords and raise awareness of this work.

Priority 4 Child & Adult Obesity

Action/Intervention	Measure	Latest Note
To deliver a 6 week 'Healthy Mums, Healthy Bumps' weight management and dietary intervention for pregnant women to support pregnancy health and develop sustainable healthy habits among families.	No. of mums referred and engaged with programme. Demonstration of behaviour change among completers.	No further health inequalities funding to deliver bespoke projects. Mums are either seen as part of Weight For It or may be offered 1:1/ group support at the gateway.
To support pregnant women to achieve and maintain a healthier weight through 3 pregnancy appointments with the healthy	No. of women supported and behaviour change achieved. No. of referrals to Healthy Mums, Healthy Bumps	

Action/Intervention	Measure	Latest Note
weight midwife service.		
To provide timely advice, guidance and signposting to families at 5 key time points through health visiting service. Refer to infant feeding lead health visitors as required. Working towards Unicef guidelines. Exploring safeguarding/emotional issues around obesity. Actively assess material infant attachment and material mood.	All families seen on time	Commissioned core contracts met
To promote breast feeding friendly environments by working with businesses, employers, food establishments and other public facilities such as shopping malls helping businesses understand the need to provide support through policies and facilities for women who want to breastfeed.	Demonstration of breast feeding friendly environments by displaying the logo No. of business reached and displaying good practice	The health team and PSB have undertaken 2 businesses walk-arounds in TW town centre, encouraging business to display the 'breastfeeding welcome' stickers. There was a positive responses from restaurants including The Nutmeg Tree, Fenwick, Basil, Pup Café AHT, Trinity Theatre. Pitcher and Piano, Zest Restaurant at Hoopers and Jamie's Italian.
To increase breastfeeding initiation and uptake in Tunbridge Wells by providing peer support.	Increase in breastfeeding initiation rates (target 95% coverage at 6-8 weeks) Contact with mothers within 48 hours of transfer home after birth or 48hrs from time of homebirth.	
To deliver an 8 week family weight management course (LEAP) in schools within our highest priority wards supporting parents with overweight and obese children through cooking, nutrition and exercise.	50 families recruited per annum (target) Families who complete to demonstrate behaviour change which supports a sustained reduction in weight. Year R and Year 6 obesity rates from the National Child	14 families actively engaged (against target 50), 11 of them were recruited from target schools. Service recruited 27 individual children (12 of whom had a BMI above 91st centile). Two children reduced their BMI z-score
To identify schools in need of support using NCMP results. Schools are supported to provide healthier environments through tailored enhancement plans, parental engagement activities, curriculum support and targeted interventions.	Reduction in Year R and Year 6 obesity as measured by National Child Measurement Programme No. of schools and families reached, interventions delivered	9 families took part in the cook and eat programme, which was followed up with the LEAP programme being delivered at the school. Eat well sessions delivered to children in year R and year 6 at Cranbrook Primary School and TGA. LEAP activity days saw 27 children and 15 parents take part. Events delivered at Cranbrook Primary School and Rushtall Primary

Action/Intervention	Measure	Latest Note
		school, which engaged 52 children, 15 parents and 1 year six class respectively. Health Team attended TAG rugby festival on 4th May with smoothie bike and promoted the service to parents and children from the borough's primary schools.
To deliver a tailored weight management programme (Move, Eat, Grow) for adults with learning disabilities to improve access to dietary support and weight management interventions.	No. of people supported Demonstration of behaviour change and weight loss for those completing the course	Bespoke interventions are no longer offered due to the withdrawal of the health inequalities funding. However where required we offer 1:1 appointments at the gateway for people with protected characteristics. We have supported a female client to lose 2.2Kg and a male client to lose 9kg. Both clients have made positive behaviour changes including building active travel into their day and cutting down on snacks.
To engage business in public health through promotion and delivery of the Kent Healthy Business Awards. This supports and tasks businesses to make improvements in 9 areas including healthy eating, smoking and physical activity to facilitate a healthier workforce. Also contributes to priority 5 & 6	No. of businesses engaged per annum (target: 1 new business to achieve national award, 10 new businesses signed the declaration, 10 themes assessed as excellent and 20 new businesses actively engaged.	Currently working with 12 businesses. One achieved excellence in absence management
To deliver the cycling strategy in Tunbridge Wells supporting an increase in the numbers who cycle	Increase in the number of people who cycle and use sustainable transport	The Tunbridge Wells Cycling Strategy was adopted in March 2016 and sets out a network of key routes that the Council is seeking to deliver with its partners including KCC. Consultants have recently been commissioned to design route improvements on the A26 between Tunbridge Wells town centre and Tonbridge town centre and also on the 21st Century Way, between Tunbridge Wells town centre and North Farm (a key employment area in the Borough). There are a number of potential funding sources being explored to deliver these schemes. Anecdotal evidence suggests that the number of cyclists on the roads is increasing in the Borough.
To provide, maintain and enable use of good quality green spaces, play equipment and leisure facilities.	Surveys establish how well spaces are being used	
To screen all eligible 40-74 year olds	50% of eligible patients invited to a health check	Current rate for those eligible invited is 48% - target is 50%

Action/Intervention	Measure	Latest Note
cholesterol levels, blood pressure, weight (BMI) and lifestyle choices (diet, exercise & alcohol); enabling early identification of risk factors for diabetes, stroke, CHD, kidney disease and certain types of dementia. Also contributes to priority 5&6	per annum (Kent Joint Health and Wellbeing Strategy Target) Advice, support, signposting and referrals for timely help.	30, 000 checks delivered across Kent in 13/14 45,000 delivered across Kent in 14/15 Meeting between KCHFT and Andy F and other Day Service managers happened on 5th April Clarity needed from LD Nursing team around duplication
To provide free school meals to all key stage 1 pupils and children from low income families so that children have access to a hot, nutritious meal daily.	No. of who have taken part versus no. eligible	Uptake is no longer monitored by schools since school meals became free to all KS1 children. Uptake vs eligibility was recorded when only children from low income families were offered the hot meal. All schools are offering this service.
To develop physical literacy in primary schools through training and support funded by sports premium funding.	Improved, higher quality PE delivered in schools, demonstrated by No. of schools worked with.	This year we have provided additional (buy-in) support to 16 primary or infant schools in Tunbridge Wells. Our staff have worked alongside primary school teachers to improve the quality of physical education in the curriculum.
To deliver the change for life clubs at primary schools across Tunbridge Wells giving children the opportunity to active and learn about healthy living	No. of clubs running across Tunbridge Wells No. of children attending clubs	Change4Life Clubs (or equivalent, as they are not all called Change4Life Clubs now) were delivered in 16 primary schools through the primary leadership programme. SSP do not have exact numbers but would suggest that each club on average has approximately 10 children in it. In terms of C4L clubs, there are no more equipment bags/resources that have been distributed this year but our role as School Games Organisers is to try and encourage all primary schools to have a club that specifically targets pupils who are the least active, have low confidence, poor motor skills etc. It's more about the philosophy than the name as it was felt before that C4L Clubs didn't sound particularly appealing to both pupils and parents. Some schools will still call their clubs C4L clubs but it's completely up to the school how they market and promote these clubs now.
To teach families and residents to cook healthy meals from scratch on a budget through mosaic cookery classes.	No. of people supported	1x course delivered so far in 2016 to 8 participants at Sheltered scheme for over 50s. 'Cookery Leader' training being provided to residents later this year to equip them to deliver this training in the future.

Action/Intervention	Measure	Latest Note
To deliver 1:1 health trainer service for people aiming to improve their lifestyle through modifications to diet, alcohol reduction, weight loss, smoking cessation and support with wellbeing. Also contributes to priority 5 & 6	No. of clients supported Demonstration of behaviour change	Currently 56% against target of 62%
To deliver the 10 week subsidised exercise referral programme across Tunbridge Wells for patients who can use exercise to support their weight loss.	No. of clients recruited (target 210 with a BMI >28) No. of clients who are actively engaged (target - 168) No. of clients demonstrating weight loss and/ or behaviour change	318 adults were recruited, of which 231 had a BMI >28. (109.1% against target) 149 of recruits remained actively engaged (89% against target) 95 lost weight 52 improved their levels of wellbeing 49 improved their diet 48 increased physical activity levels Average weight loss = 2.68% (89% progress towards target)
To deliver the 10 week free adult weight management programme (Weight For It), helping people to manage their diet and lifestyle in a community setting for clients whose BMI is below 40.	Average weight loss (target +3%)	318 adults were recruited, of which 231 had a BMI >28. (109.1% against target) 149 of recruits remained actively engaged (89% against target) 95 lost weight 52 improved their levels of wellbeing 49 improved their diet 48 increased physical activity levels Average weight loss = 2.68% (89% progress towards target)
To deliver the tier 3, 'For healthy weight' weight management intervention including, dietary, emotional and exercise support in patients whose BMI is above 40.	No. of people engaged No. of people losing weight No of people making behaviour changes	600 people engaged Kent wide (excluding Swale). Two year analysis demonstrates that 97% of clients lost weight. Average weight loss was 10.5Kg pp. Average increase in wellbeing was 6 using the Rosenberg scale.
To deliver cookery, nutrition, physical health, wellbeing and walking sessions for users of Tunbridge Wells Mental Health Resource Centre (TWMHRC)	No. of service users supported to live healthy lifestyles	

Priority 5 Smoking related deaths

Action/Intervention	Measure	Latest Note
Midwives to measure CO levels in all pregnant	Reduction in the number of mums that smoke	319 women accessed the service. 59 pregnant women quit Kent

Action/Intervention	Measure	Latest Note
women and refer smokers to the 'Baby Clear' service providing vulnerable families with early help to quit	during pregnancy. No. of referrals made	wide
To train all children's centre staff in level 1 brief intervention for smoking cessation to improve access to advice and support when giving up smoking	No. of staff trained No. of people supported to quit and No. of referrals made	Children's services have recently undergone a restructure. Consequently no training has been delivered. However Simon Fry (simon.fry@kent.gov.uk) is going to prioritise in local action plans. Update should be available in line with next review report for HIAP
To provide in house smoking cessation resources to local businesses, where a minimum of 8 quitters have been identified, including 1:1s and quit clubs.	No. of sessions run and no. of people quit per annum	116 referrals 82 with outcomes 57 quits 69.51% success rate.
To deliver dedicated 1:1, group and telephone support to people who wish to quit in community settings	No. of people quitting No. of sessions held	3417 quits Kent wide 55% success rate
To raise awareness of the effects of 2nd hand smoke and the benefits of stopping smoking through working with patients attending pulmonary rehab services during the acute (smoking) project.	No. of sustained quitters	Talk given regularly with TW pulmonary rehab team.
To supplement the Kent schools curriculum with tobacco education to raise awareness of the risks of tobacco use	No. of schools and children reached	
To deliver brief advice training for frontline staff so they are equipped to carry out brief interventions and signposting with people who may be supported to quit smoking.	No. of sessions delivered and No. of people reached	Brief advice training delivered across all sectors on a continuous basis as required, to all relevant staff.

Priority 6 Alcohol misuse

Action/Intervention	Measure	Latest Note
To re-launch the Safer Socialising Award and encourage licensees to take part in the scheme	No. of awards issued	No uptake of the safer socialising award during 15/16
To enforce the Town Centre Alcohol Control Zone	Number of section 27s given by police which have been monitored by CCTV	Police no longer issuing section 27s
To exclude individuals convicted of violent	No. of 'Pubwatch' exclusions in force	Q1 = 20, 7 for violent crime

Action/Intervention	Measure	Latest Note
offence from 'Pubwatch' licensed premises.		Q2 = 23, 9 of which are for assault Q3 = 15, 8 of which are for violence Q4 = 13, 7 of which are for violence
To use safe town radios to prevent and detect violent crime, by sharing intelligence between licenses/ retailers, CCTV control room and police	Pubwatch instigated incidents monitored by CCTV No. off violent offences monitored	Q1 = 40 Q2 = 46 Q3 = 60 Q4 = 32
To review all hate crimes within the borough at CSU meetings and put into place suitable interventions and referrals where appropriate	No. of hate crimes recorded in the borough	Q1 = 16 (3 related to disability, 1 homophobia and the rest were racial) Q2 = 22 (2 for homophobia, 1 religious and 19 racial) Q3 = 35 (30 racial, 1 homophobic, 2 disability and 2 religious) Q4 = 27 (21 racial, 3 homophobic, 1 disability and 2 religious)
Provide licensing training to staff around responsibilities when serving alcohol; including: making sure they adhere to the licensing act, under-age sales, legal highs and drug use.	Number of training sessions offered by Kent Police	10 premises received training during 2015/16
To deliver a holistic approach to drug and alcohol treatment and support including (blood borne viruses) BBV testing, vaccinations, mental wellbeing scores, mental health and substance misuse assessments, groups, clinics and support with sleep hygiene, relaxation and safer use. Involves joint working with health professionals and hospitals.	No. of people supported and outcome of behaviour change	290 clients from Tunbridge Wells engaged in structured treatment, and 137 clients discharged as Treatment Complete.
To deploy substance misuse workers to hotspots within the borough to carry out 1:1 and group work with adults and young people	Number of young people worked with through 1:1s and early intervention Number of referrals to KYDIS via Kent Police	17.5%
To deliver brief (alcohol) advice training to public facing staff so that they are able to offer brief intervention and signposting, improving access to support for the public.	No. of sessions held and no. of people trained.	111 professionals from T/Wells attended IBA Training (breakdown of types of organisations attending available on request

Agenda Item 8

To: West Kent Health and Wellbeing Board, 20 December 2016

Report: Workforce and Making Every Contact Count (MECC)

Summary

This report aims to do two things:

1 Provide an overview of how Health Education England, working across Kent, Surrey and Sussex (HEE KSS) is supporting the delivery of the Kent and Medway Sustainability and Transformation Plan (STP); and

2 Provide an overview of the Making Every Contact Count programme in the context of the prevention agenda.

Part A – HEE Overview

1. Background

a) In December 2015, the NHS planning guidance set out how every health and care system in England was to produce a multi-year Sustainability and Transformation Plan (STP) to show how local services will evolve and become sustainable, ultimately delivering the Five Year Forward View vision of better health, better care and improved NHS efficiency.

b) In the guidance around the STPs, it was announced that Health Education England would establish 'Local Workforce Action Boards' (LWABs) with the aim of coordinating and supporting the workforce requirements of each STP 'Footprint'.

c) In the area covered by Health Education England Kent, Surrey and Sussex (HEE KSS) there are three STP footprints:

i. Kent and Medway
ii. Sussex and East Surrey
iii. Surrey Heartlands

d) Each STP footprint has a corresponding LWAB that is currently being established. Workforce is a key enabler for each STP and within the STP governance arrangements for Kent and Medway it has been identified as one of the work streams to take forward. The LWAB will support this work. Each LWAB is to be co-chaired by the Local Director of HEE KSS together with a senior lead from the footprint. In Kent and Medway, this is Philippa Spicer and Hazel Carpenter respectively. Its role will be to facilitate the development of workforce solutions to support the challenges in the footprint and to manage any investment from HEE which will enable the delivery of agreed priorities/implementation of the LWAB action plan.

2. Funding and Support

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

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

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

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

d) Kent and Medway has already benefitted from £200,000 allocated to support the implementation of the recommendations of the Kent Health and Wellbeing Board Task and Finish Group.

e) The funding above is in addition to this year's workforce development monies distributed to the system by HEE KSS. These are primarily delivered through the following Skills Development Strategy (SDS) programmes and Workforce Enabling Programmes:

- Skills Development Strategy programmes:
  i. Dementia
  ii. Primary Care
  iii. Emergency Care
  iv. Children and Young People
  v. Patient Safety (Human Factors)
  vi. Intellectual Disabilities
  vii. Mental Health

- Workforce Enabling programmes:
  viii. Technology Enhanced Learning
  ix. Career Progression – Bands 1-4
  x. Integrated Education
  xi. Public Health

Part B – STP: Workforce and Prevention

a) A whole system STP workforce group has been set up – in addition to the other STP work groups, e.g. prevention and mental health etc. The Workforce group consists of representatives from KCHFT, KMPT, KCC, universities, Health Education England and key medical and social care workforce leads including public health. The workgroup will tackle building resilience in the Kent and Medway workforce, including retention and recruitment. Other important issues that will be tackled will be current and future training needs, embedding prevention into core competencies and understanding new ways of working. The workgroup is currently focusing on a baseline mapping of workforce gaps and will report to the Programme Office of the STP.

Part C – Making Every Contact Count

a) MECC is an approach that aims to support public facing workers to "make every contact count" by using opportunities during routine contacts to support, encourage and enable people to consider healthy lifestyle behavioral change in order to help maintain or improve their mental / physical health and wellbeing.

b) The MECC programme has four key elements and these are:

i. Organizational preparation;
ii. Skills development;
iii. Implementing MECC delivery;
iv. Evaluation.

c) Within KSS, HEE provided funding to pilot MECC with six Spearhead sites that were initially recruited in early 2016 from a range of organizations including health, social care and housing in order to support delivery of key MECC activities. Early work across the region focused primarily on skills development and on designing a blended learning programme that could adequately meet the training needs of a diverse range of public facing workforces.

d) A key part of developing the MECC blended learning programme was to map it to existing best practice frameworks such as NICE guidance[1][2], NHS Yorkshire and Humber Prevention and Lifestyle Behaviour Change Framework[3] and National Occupational Standards.

e) In June this year, the blended learning programme for MECC in KSS was finalized and consists of a three staged model:

i. **Core competency** – an eLearning package for the acquisition of underpinning knowledge around MECC, healthy messages and an introduction to skills;

[1] National Institute for Health and Care Excellence (NICE).Behaviour change at population, community and individual levels. London: NICE, http://guidance.nice.org.uk/PH006 (2007)
[2] NICE Behaviour Change: Individual Approaches https://www.nice.org.uk/Guidance/PH49 (2014)
[3] NHS Yorkshire and the Humber. Prevention and lifestyle behaviour change competence framework. NHS Yorkshire and the Humber, http://www.makingeverycontactcount.co.uk (2010)

ii. **Skilled competency** – an ½ day face to face package for the acquisition of skills and confidence to undertake healthy conversations around health and wellbeing;

iii. **Train the Trainer** – A bespoke face to face training day that aims to develop future MECC Trainers in order to embed & sustain MECC within organizational structures.

f) The core competency component of the blended learning programme has been developed as a 2-hour online learning package and is now available on the 'e-learning for health' portal.

g) The skilled competency and train the trainer element of the above programme have already been commissioned and these are currently being delivered by an external training provider, Social Marketing Group (SMG). The ½ day skilled competency training is expected to reach 300 frontline staff by the end of January 2017 and a further 42 people will be trained as MECC Trainers by March 2017.

h) Whilst the initial six MECC Spearheads have been progressing well in KSS the emergence of STPs and the need to re-focus efforts on prevention now requires additional longer term planning to ensure that MECC is aligned with local STP aims and objectives.

i) For example, there are at least three key issues in delivering MECC across Kent and Medway and these are:

i. Harnessing targeted workforces e.g. 'housing sector';

ii. Industrializing preventative working across all sectors and scoping the training needed for this approach;

iii. Working with new ICO/MCPs in embedding a new culture of pro-active health and social care.

j) Thus, as a way of addressing these issues in Kent and Medway future MECC roll out will incorporate the following:

- Integration of MECC into the work of the Kent and Medway LWAB and other key STP groups looking at workforce in order to establish local workforce requirements;

- Alignment of MECC with the work of Community Education Provider Networks (CEPNs) to support roll out within Primary Care;

- Further Integration of MECC into training and educational programmes for NHS clinical and non-clinical staff;

- Greater expansion of MECC into NHS settings such as acute care trusts, community health trusts (including mental health) and Primary Care;

- Greater alignment of MECC with existing initiatives and approaches within health and social care e.g. the Macmillan Care and Compassion Programme for Health Care Assistants.

k) Across Kent and Medway, the above work will be led and supported by the Workforce group in the STP and involve HEE and public health as key coordinators. Additionally, all training providers and educational leads will be engaged with this work in time. The establishing of a public health Academy currently being set up across the London & KSS Deanery will also help with MECC implementation and training.

Part D - Recommendations

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

Report authors

Kevin Driscoll
MECC KSS Project Lead, Health Education England working across Kent, Surrey and Sussex
Tel: 07713 304049 Email: kevin.driscoll@medway.gov.uk

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

Jess Mookherjee
Consultant in Public Health, Kent County Council
Tel: 03000 416493 Email: Jessica.mookherjee@kent.gov.uk

Appendices

None

Background papers

None.

Agenda Item 10

To: **West Kent Health and Wellbeing Board**

From: **Jane Heeley, Chief Environmental Health Officer, TMBC and Healthy Weight Lead WKHWB**

Lynne Weatherly, Health Portfolio, Tunbridge Wells and Member Lead for Healthy Weight, WKHWB

Date: **20th December 2016**

Subject: **National Tacking Obesity Conference and Healthy Weight Update**

1. Introduction

This report provides feedback from the National Tackling Obesity Conference on 22nd September 2016, attended by Councillor Lynne Weatherly and Jane Heeley, and considers how the learning from this event might be used to further update our Obesity and Overweight Action Plan to positive effect.

2. Key points from the National Tackling Obesity Conference

2.1 The conference was reminded of the scale of this serious health epidemic:

- one in three children in Year Six are overweight or obese;
- seven out of ten men and six out of ten women are overweight or obese;
- in the last ten years obesity prevalence has increased from 15% to 25%;
- socio-economics are a significant contributor to this.

The conference programme focussed on national guidance and monitoring, through contributions from the authors of the Childhood Obesity Action Plan and NICE, as well as highlighting a number of interventions that have achieved some strong outcomes.

2.2 The presentation from the NICE representative reviewed the main themes that have been identified in the NICE Obesity Pathway and perhaps not surprisingly several of these are themes have been recognised by the Board and its members in developing the Healthy Weight Action Plan; for example the need for practitioner training, evaluation of commissioned activity, identifying barriers for change and addressing those during interventions and additionally the need to take a long term strategic approach both nationally and locally to reducing prevalence. Locally Boroughs and Districts are working with KCC, recognising that local environment is important to enabling and sustaining change, recognising that healthy behaviours need to become part of everyday life and interventions need to be tailored to the needs of the individual.

2.3 It was interesting to note that the NICE evaluation on cost effectiveness showed that moderate cost interventions (£10 to £100 per head) were deemed to be cost effective if they generated a weight reduction of just one kilogram, if that was maintained for life. Low cost interventions (£10 or less per head) were cost effective if a weight loss of less than one kilogram was achieved, even in the short term. Exercise referral schemes had been shown not to be cost effective if the individual was inactive or sedentary, but otherwise healthy.

2.4 Understandably there was much debate round the effectiveness of professionals from across the health sector to talk to patients or clients about overweight and obesity. Different schools of thought emerged from both presenters and the audience. There is clearly a mixed situation in practice, with some professionals readily taking the opportunity to engage on these matters with patients and but also the acknowledgement that many do find these conversations difficult and would benefit from training in having those difficult conversations sensitively and effectively.

2.5 A number of high profile case studies/interventions were discussed in detail, including:

- The Deal for Health and Wellness – Wigan's approach to Weight Management – www.wigan.gov.uk ;
- Brighton – Sugar Smart City – www.brighton-hove.gov.uk ;
- HENRY – Health, Exercise and Nutrition for the Really Young – www.henry.org and
- UK Active Kids – physical activity programmes www.ukactive.com

More details of all these initiatives are available through the website links, however, there is not one thing that they had in common apart from huge enthusiasm and passion for their project. In part Wigan's success could be attributed to the pooled budgets across the Council and CCG, this has greatly facilitated integrated working and been able to resource 8,500 places per annum on their Lose Weight, Feel Fabulous weight management programme. To date participants have numbered 23,000and shed 20,000 pounds between them.

2.6 One of the principle sessions outlined the content of the national strategy for Childhood Obesity – A Plan for Action, which was published in August. It includes the following key actions that are intended to reduce childhood obesity:

- Introducing a soft drinks levy – for both producers and importers;
- Taking out 20% of sugar in products – particularly food consumed by children, e.g. breakfast cereals, yogurts etc. This will be a voluntary scheme for now;
- Making healthy options available in public sector buildings – hospitals, council offices and leisure centres;
- Provide support with the cost of healthy food for low income families – continue with the Healthy Start Scheme
- Clearer food labelling
- Children – 1 hour of physical activity
- Healthy rating scheme – administered by Ofsted, including healthier school food

- Enabling health professionals to support families – MECC

Full detail of the document can be found at:
https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action

The content of the Plan was certainly not welcomed by all, with some strong expressions that the Strategy had not gone far enough in controlling the food manufacturing sector and advertising of unhealthy products.

That said, there are a number of areas for the Task and Finish group to consider, which are outlined in the following paragraph, along with more general learning points from the conference, and with the Board's agreement will be incorporated into our Action Plan and presented at a subsequent meeting.

3. Actions for this Board to consider

- Identify the range of interventions that should be monitored and review the cost effectiveness of these and their outcomes over time, including outcomes from Tier 2 and 3;
- Address the provision of healthy food offers in public sector buildings;
- Continue developing the MECC strategy and progress training at scale and pace, consider whether alternative training is available to deal specifically with conversations about weight;
- Ensure we know where we need to best target our resources to motivate change and identify the local resources and assets to do this;
- Consider how we can get local communities engaged with this agenda through our wider services;
- Review what we are doing around early intervention and develop plans around this;
- Explore what technology is available to support individuals' on this pathway; and
- Ensure that Board members maximise opportunities for engagement with the Kent Change 4 Life campaign.

4. Recommendations

Through this report the Task and Finish Group would like to recommend to the Board that we review how these actions can be incorporated into our existing Action Plan and present to the next meeting of the Board the relevant changes, with suggestions on how they will be implemented.

Jane Heeley
and
Lynne Weatherly

WKHWB Obesity T&F Group

Meeting 1st November 2016

Present: Heidi Ward, Val Miller, Yvonne Wilson, Malti Varshney, Sally Allen, Wayne Gough and Sarah Lovell Jane Heeley

1. **Actions from 20/7/16**
    - Commissioning T3/4 - KCC will produce an options paper for consideration by CCG early 2017. Expected that T3 will be commissioned by CCG as per NICE standards
    - T4 current provider likely to continue
    - T2 commissioning needs to link into NDPP.
    - NHS England funding for T has not yet been allocated
    - Numbers of T3 individuals presenting on T2 programmes needs to be considered. T2 is not a substitute for this programme.
    - Work still needed on pathway – KCC/CCG

2. **Diabetes Prevention Pathway**

    - There is likely to be overlap between T2 and the NDPP, the key considerations are GI and BMI. Guidance is that those presenting with both high should be referred to DPP.
    - Ignius is the Kent provider (also include Sussex and Surrey)
    - There is a local incentive scheme in place to which most WK GP's have signed up to.

3. **National Childhood Obesity**
    - Report to WKHWB – Bob Bowes met with LCPG leads who have highlighted concerns over XS weight as a priority and expressed that the key is to early intervention and need better understanding of maternity and health visiting services and Prevention Pathways WK HWB has a role therefore in influencing the commissioning of children's and maternity services.
    - All LCPG Groups need a formal connection with NCMP groups (name change to Childhood Obesity Operational Groups, which will now consider age 0-19) – VM

- MECC issue to consider here – YW asked how MW/HV incorporate lifestyle discussions with clients?
- How do we know population level outcomes are taking place? There needs to be an unpicking of the extent to which organisational boundaries are barriers to progress and how the transformational approached that are needed at operational levels are been communicated to health professionals.
- Health Visitor procurement process was discussed
- Suggestion that there is a WK Childhood Obesity Symposium to review and challenge current practice.
- ACTION: Lynne Weatherly write to BB requesting there is an obesity audit in all commissioning plans and that NICE quality standards are included.

4. Campaigns update – joined by Wayne Gough and ??

- KCC commissioned Agency continues to work on C4L messaging, in particular 3 major areas:
  - Continuing to promote C4L in Kent – radio campaign signposting to website, physical activity planner/healthy lunchbox suggestions for schools
  - Support for front line staff – working with HV's; Children's Centres; Healthy Living Staff and GP's – testing out what a good conversation looks like, what support/resources are needed and whether they use C4L and to what extent.
  - Support for the wider system – tweets for partners and partner resource hub.

- How is success and ROI being measured? Reviewing numbers of visits to the C4L local site and numbers of apps and downloads as well as the sign up to various elements. Looking at post campaign evaluation.

- **ACTION – WG to send details**

- **NMCP work - VM** – 36 schools have been identified in each District and 75% of these have engaged with the Sugar Smart programme. Evaluation is currently taking place. ACTION – Sarah to provide details around ROI and what was most successful in triggering behaviour change.

- Healthy Start – to what extent can District Revs and Bens Teams help promote the take-up of free vitamins and vouchers? ACTION: JH/WG to explore with TMBC Revs and Bens Manager.

5. **MECC**
    - There is currently a Housing pilot running in Kent. What is the feedback from this? ACTION: JH to liaise with TMBC Housing.
    - Need to keep an eye on PH(E) plans to deliver MECC and MV is meeting with them next week to discuss how different professional groups can be engaged and what approaches might work best for each. **ACTION: MV to feedback.**
    - MV also meeting with the workforce lead for the STP and look at how MECC can be incorporated into that. **ACTION: MV to feedback at next meeting.**