NHS
West Kent
Clinical Commissioning Group

A Vision for a Vibrant and Sustainable Future For Out of Hospital Services in West Kent 2016 - 2021

1

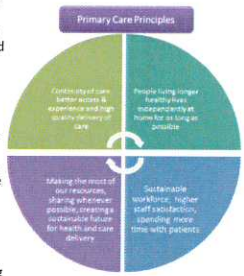
Foreword

- *I decided to become a GP in 1984. The idea of practising holistic medicine in the community with a stable team of fellow professionals has always appealed to me. Having been at my practice for nearly thirty years, I recognise my patients in the street and remember their very personal stories. I have seen their children born and been able to help as they get older. It has been a privilege to share these journeys with my patients, even right up to the end of their lives.*
- *But during this time the star of general practice and primary & community care has fallen. Investment in "out of hospital" services and personnel has fallen back compared to "in hospital" services. So we now see some practices being unable to meet their costs and fewer junior doctors wanting to become GPs. There's also been a fourfold increase in demand over my working life. It's not just about the numbers of patients; the population's needs are more complex. All this forces a real crisis on General Practice.*
- *Yet, the increase in people with multiple long term conditions, frailty and complex social, emotional, medical and psychological problems can only be addressed by harnessing the holistic skills unique to General Practitioners*
- *To meet these challenges, Primary Care has to change. It has to become more capable but also more capacious. GPs need to work more closely with other professionals, leading multidisciplinary teams, managing patients who are more unwell and fostering joined up care..*
- *I am absolutely convinced that strong and effective General Practice is essential to serve the majority of health needs in West Kent. To play their role in this, GPs will need to work in new ways within bigger teams. This strategy explains how commissioners will make this happen.*

Dr Bob Bowes, Chair of NHS West Kent Clinical Commissioning Group

Vision for New Primary Care

- Clinicians are working in practices they are proud of, delivering care to patients in a wider truly integrated team.
- 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 are in place to allow clinicians to spend more time with their patients, with greater continuity of care and higher quality care for their patients.
- The system allows easy access to the right clinician at the right time, whilst patients with complex needs are managed proactively in the community by a wider multidisciplinary team headed up by their GP and appropriate specialist.
- Everything is underpinned by a shared clinical record.
- The West Kent population benefits from strong primary care provision across Primary Care Strategy for West Kent 2016-2020



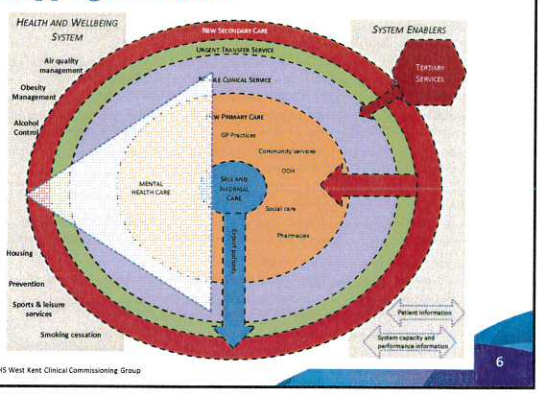
Purpose of the Strategy

- This strategy aims to improve the health, well-being and independence of people living in the West Kent through delivering a step-change in more accessible, sustainable and higher quality out-of-hospital care.
- The outcome will be a range of services from primary, community, children & families and mental health care working in a way which wraps around the patient with the support of social care to ensure that patients stay healthier, independent and at home for longer.
- There will be local solutions in place for better use of resources, allowing more patients to be treated in the most appropriate manner, a better work / life balance for those working in primary and community care and sustainable out of hospital provision.
- The strategy has both to strengthen General Practice and develop New Primary Care.

Mapping the Future

- Mapping the Future (MTF) is a programme of work in West Kent that aims to describe what the health and care system needs and what a modernised health and care service for the 480,000 people who live in West Kent will look like.
- The programme produced an initial future picture of the modern, efficient health and care services that need to be provided in order to meet the changing needs of people in West Kent over the next 5 years. This programme is delivering the NHS Call to Action within West Kent.
- Mapping the Future sets out a whole system approach for West Kent where all health and well-being system partners use their individual and collective efforts to tackle the root causes of health and well-being problems, where people are encouraged and supported to take greater responsibility for their health and healthy choices (the Blueprint).
- Identified the essential role of New Primary Care which is defined as integrated, highly productive and holistic health and social care services delivered close to or in peoples homes. Also foresaw a greater emphasis on prevention and self care. It is a model for more capable out of hospital services to reduce the reliance on the secondary sector
- New Primary Care is an expansion of the capacity and capability of out of hospital care and can only take place on a platform of strong General Practice
- Mapping the Future matches the Five Year Forward View and the Forward view for General Practice. This blueprint places self and informal care at the centre, enhancing the capacity of communities and individuals to support themselves and each other. People are fully informed and take part in planning their care helping are supported to stay at home and independent longer

Mapping the Future



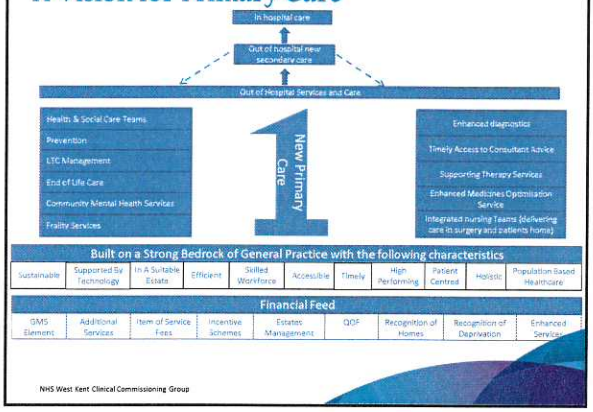
Five Year Forward View

- The *5 Year Forward View* sets out a vision of transformation in health services with emerging 4 key models of care delivery - Primary & Acute Systems (PACS) & Multi-speciality Community Providers (MCPs) models, Integrated Urgent Care Systems & Care Home Commissioning.
- MTF was revisited in light of the Five Year Forward View and the clinical direction agreed that the design of transformed health and care service in West Kent are likely take the form of:
  - **New Primary Care** under a MCP model to deliver 'Out of Hospital' Preventative, Proactive and Planned care services
  - **Integrated Urgent care services** to cover both in and Out of Hospital urgent care services led by Secondary care.
  - **New Secondary Care** to deliver specialist services that need a hospital infrastructure or are better placed in the hospital on specialist expertise, quality or economic basis.

GP Forward View Commitments

- Investment – to accelerate funding for primary care
- Workforce – to expand GP and wider primary care staffing
- Workload – reduce practice burdens and release time
- Practice Infrastructure – develop primary care estate and invest in technology
- Care Redesign – a major programme of improvement support for practices

A Vision for Primary Care



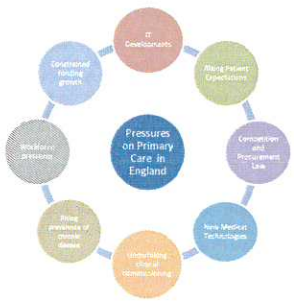
Built on a Strong Bedrock of General Practice

- We aspire to General Practice
  - which is sustainable,
  - in suitable estate,
  - is efficient,
  - has all suitable IT support,
  - has a skilled workforce,
  - is accessible and timely,
  - is high quality and good value for money (including reducing bureaucracy),
  - is holistic and helps to address inequalities
- We will help this by CCG programmes to:
  - help manage demand,
  - strengthen the workforce,
  - develop IT in General Practice
- We will provide disproportionate investment to those practices that face particular problems of demand.
- We will support the development of GP estate.
- We will reduce the complexity of reporting required from Out of Hospital Services

Current Primary Care

- Primary care is defined as the first contact of a patient with a healthcare provider, usually a GP, dentist, pharmacist or optician, in a given episode of illness; it is people's entry point for the prevention and treatment of illness.
- Although people often use 'Primary Care' to mean General Practice, the sector includes a rich diversity of professionals ranging from GPs, Nurse Practitioners, Nurses, Opticians and Pharmacists through to allied health professionals and social care workers.
- Advances in technology and changing demographics mean that, with the right premises and the correct skill mix, a wider range of services can be delivered in a primary care setting.
- Primary Care also has a key role to play in improving health outcomes and reducing health inequalities, promoting healthier lifestyles and prevention
- Primary care services are effective gatekeepers for secondary care and thus ensure that the populations needs are met with high quality and value for money.
- Primary care works closely with Community care, Social care and Mental Health Providers yet the commissioning and provision of these services are not integrated or strategically aligned
- Scale and impact of primary care in the UK
  - GPs and nurses in general practice see over 800,000 people a day;
  - dentists and dental teams see around 250,000 people per day;
  - opticians provide around 12 million NHS sight tests each year; and
  - an estimated 1.2 million people visit a community pharmacy every day.

Challenges in Delivering Core GMS



Challenges in Delivering Core GMS 2

- Present contracts are either activity based or block contracts, depending on the particular sector of the NHS. The former reflects activity in price, not cost and can also lead to activity driving budgetary demand.
- Block contracts run the risk of under performing, with consequent unmet need. In both cases, lack of clarity in specifying both outcomes and the population to be served can lead to under or over performance
- In addition, the multiplicity of commissioners means that there is duplication and omission in assessing need, designing and specifying pathways and delivering outcomes.
- In order to address these weaknesses, place based commissioning offers the opportunity to assess the needs of the whole population, design and agree strategy that meets those needs and then utilise the totality of resources available to commissioners.
- Contracts must therefore specify in detail the outcomes required for the population and increasingly require providers to work together across different sectors to deliver services together.
- Providers will be required to deliver the same services for the same contract and not allowed to apply their own exception criteria.
- Performance will be managed across all contracts. Budgets will be merged across existing commissioning boundaries.

West Kent Primary Care Services: the Case for Change

Strengths

- High calibre, committed workforce
- High quality General Practice compared to national picture
- Good if informal relationships between practices

Weaknesses

- Primary care services are not integrated and therefore a)do not provide a seamless experience for patients and b) could be more productive
- Variable quality across all sectors of primary care
- Demands on health services are increasing but no new primary care investment has been made available
- The primary care estate is variable, lacks flexibility and is not being fully utilised
- The GP workforce is overloaded
- No local system leadership of out of hospital care

West Kent Primary Care Services: the Case for Change

Opportunities

- West Kent CCG operating plan: to develop new primary care and enhance prevention, improve timely diagnostics and health improvement with local authorities
- People are living longer and our opportunities to lead fulfilling lives into old age have grown.
- Improvements in medical and information technology allow better care closer to home
- Potential for enhanced capability and capacity of New Primary care to help the population to live longer and lead fulfilling lives into old age have grown
- Good training arrangements in place
- More interventions are possible in a primary care setting due to Medical and IT advances
- Co-commissioning of GP services

Threats

- Care is fragmented, of varying quality, lacks capacity and has been underinvested. It has not realised its productive potential
- The current model is not flexible enough to adapt services for the most vulnerable in our community
- The demographics of the population are changing. Society is ageing, with an increasing number of people living with long-term conditions and frailty
- Lifestyles have changed and continue to change, affecting our healthcare needs and expectations.
- Traditional GP opening hours may not suit some people while some are less willing to wait for appointments
- Large list sizes in some area making it difficult for GP to deliver anything other than core services

Benefits of Strengthening General Practice

Building teams of community and complex care nurses round clusters of practices who serve populations (of 30-80k, depending on geography) will

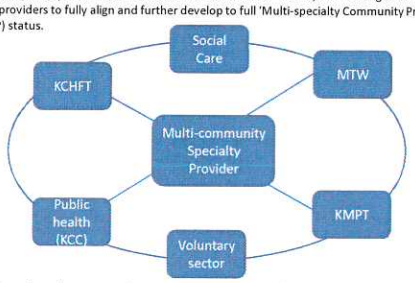
- enhance access to diagnostics and specialist nurses and advice from Consultants
- help "make every contact count" and empower patients to take responsibility for their own health
- enhance mental health provision outside hospital
- prevent ill health
- support vulnerable families
- deliver better care for patients with long term conditions, those who are frail or near the end of life, those with dementia, those at higher risk of hospital admission and those with mental illnesses
- Maintain the crucial role of the GP as the senior diagnostician in primary care

Benefits of Federated Working

- General practice teams of the future will be working with groups of other practices and providers as federated or networked organisations. Such organisations permit smaller teams and practices to retain their identity (through the association of localism, personal care, accessibility and familiarity) but **combine 'back-office' functions, share organisational learning** and **co-develop clinical services**.
- **Federated or networked practices** are therefore **well positioned to act as the provider arm** of local communities **and** can work together **to provide extended services** (such as those currently defined as 'enhanced services'), as well as **providing community nursing** services and **GPs with extended clinical roles**.
- Within federations, patients are more than likely to be able to self-refer, if they wish (or be cross referred within the federation), for **physiotherapy**, **talking therapies** and other services provided in **community-based clinics**. Patients who require routine care will be more than likely to receive this from a **range of community-based providers** working as a **team – including primary care nurses, healthcare assistants, pharmacists, physiotherapists, mental health workers and GPs.**
- Practices within federations will offer more community services to the population registered within their respective practices – for example, **dietetic services**, **podiatry,** and outreach services dependent on GP skills (e.g. **minor surgery** and **complex contraceptive services**).
- Some practices will form large federations, incorporating hospital, third-sector, private and community providers.
- The GP of the future is likely to be contracted using a number of arrangements, including, but not exclusively, as a salaried practitioner (either as part of a larger provider organisation, a federation, foundation or equivalent trust, or an employee of a third-sector and/or private company organisation) and/or as a self-employed practitioner.
- Federated organisations will be better able to **coordinate out-of-hours care** and ensure the provision of personalised care for those patients who particularly require continuity with their treating team, both in and out of hours. They will also be better placed to monitor, understand and **manage inappropriate variability** in clinical performance, through **joint learning approaches, audit, peer review and other quality-improvement mechanisms**.

Integrated Working – an MCP Model

- Our new primary care model is based on 'hub and cluster' model, but working with the other local care providers to fully align and further develop to full 'Multi-specialty Community Provider' (MCP) status.



- Getting serious about prevention, empowering patients and engaging communities, smarter use of technology and efficiency and more money
- Empowering patients to take responsibility for their own health

Why an MCP over a PACs Model?

- The CCG will set out a commissioning & financial framework for NPC in West Kent with a view to commencing implementation in 2017
- In west Kent we have a good primary care infrastructure with reasonably good performing practices
- We are not able to implement a MCP model for every practice, so we will be seeking to cluster practices together and we envisage that the two emerging federations will evolve to become part of our MCP model
- The CCG wish to work proactively to nurture and evolve our current federations into potent MCPs over a 2-year period
- From 2016/17 onwards, the CCG will be seeking to reconfigure provider contracts aligning the delivery teams of KCHFT and KMPT around the two West Kent GP federations and for provider leadership to be integrated with Federation leadership
- If West Kent Federations and their provider partners are not in a position by 2017 to play a strong part in the new delivery model then a PACS model with the local acute trusts taking the lead may be the only viable choice for NPC. This would go against the wishes of the CCG membership and significantly reduce the value of the contribution to the local health economy made by General Practices having Independent Contractor status

New Model of Primary Care

- The 'hub and cluster' model proposed was developed by considering three key issues:
  - **Individual General Practices** - how can practices retain some autonomy, independence, flexibility and continuity within a new model?
  - **General Practice at scale** - how can practices work SMART together, have a 'collective voice' in the system, share the workload and achieve economies of scale to achieve sustainability?
  - **Multi-speciality Community Provider** - how can general practice work with health and care partners to extend primary care services and extend primary care hours in an integrated patient-centred way, through access to multidisciplinary and specialist advice and support?

Why this model of delivery?

- Achieves Integrated delivery
- Ensuring a critical mass of patients to sustain desired range and levels of service
- Ability to deliver required patient and service outcomes
- Clinical interdependencies
- National thinking and experience of Vanguards
- Value for money from delivering primary care at scale
- Ability to recruit and retain a sustainable workforce

Emerging Primary Care Hub & Cluster Model

The Five Year Forward View sets out a clear policy direction for General Practice to evolve into Multispecialty Community Providers (MCPs). We are underway to design a new MCPs hub and cluster model for primary care in West Kent, which will allow primary care to work at a larger scale reducing the need to go to hospital but ensuring personalised care for patients is maintained.

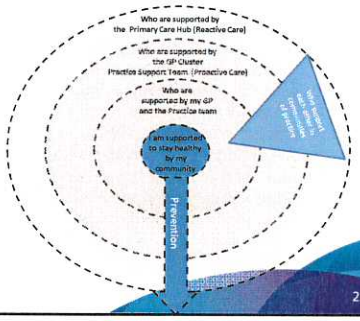
The aim is to establish a new model of care in which clinicians and other care professionals want to work, and that local people want to use: a model that results in better local care.

The hub and cluster model will have the patient at its centre with a named GP and the practice based support team providing in hours GP services for the patient.

The registered list, based in General Practice, will remain the foundation of NHS care.

The Primary Care Cluster will see GP Practices coming together to deliver services as provider networks.

The centralised Primary Care Hubs will provide extended access to patient services, with all elements of the model working together to provide wrap around out of hospital care for the patient.



Primary Care Hub & Cluster Model Outcomes

- Serve a population of patients (to be determined) in a building fit for purpose
- Deliver extended opening to cover 7 day access and additional services (including diagnostics, imaging and CT).
- Create synergy between services by bringing them together e.g. health & social services and voluntary services & public health.
- It will involve the transfer of community services and some existing secondary care services' on a non PBR basis.
- Use a centralised call centre (with ability to offer prescribing out of hours)
- Offer step up and step down beds
- Offer a range of health promotion and prevention services, helping patients to live independently for as long as they wish to
- Offer inpatient and outpatient therapy and ' day case' services.
- Integrate district nurses, health care assistants, therapists, mental health services, social workers, health and social care coordinators palliative care nurses and health visitors, and offer new, innovative ways of providing care
- Use the single integrated patient care record/Care Plan Management on GPIT systems
- Use a principal clinical system that meets the GPSoC standards that will support on line booking for patients, on line access for patients to their records, the ability to receive electronic messages from other care providers (including discharge letters and notifications, transfer of care messages, test results and the ability to generate electronic referral messages)
- Maximise use of other technologies e.g. telemedicine and consider virtual delivery options
- Provide access to common space and facilities e.g. additional rooms/training facilities/medical school/CEPN

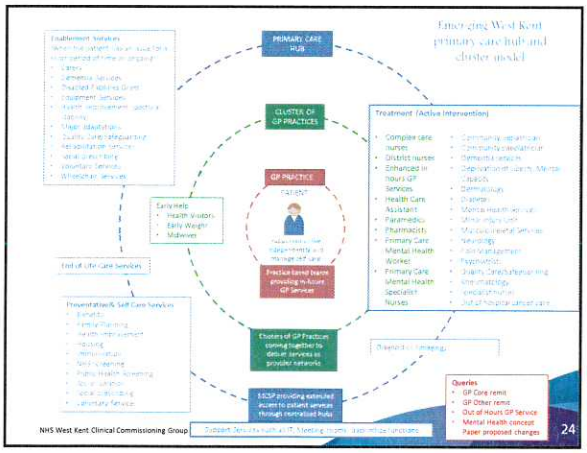
- Encourage general practices to work together to cover a population of patients (to be determined)
- Have teams of staff employed by the hub or its agent "wrapped around" a group of practices serving a minimum number of patients (to be determined)
- Have some roles working within the hub and constituent practices serving a minimum of number of patients (to be determined) e.g. complex care nurses and some other health professionals, dieticians, pharmacists, therapists and midwives

- Use existing practice teams
- Evolve to cover populations of at least 8000 patients (to meet the NHS England threshold for investment)

- A reduction in outpatients
- An increase in complex cases
- A growth in repatriation from tertiary sector

The Cluster Team

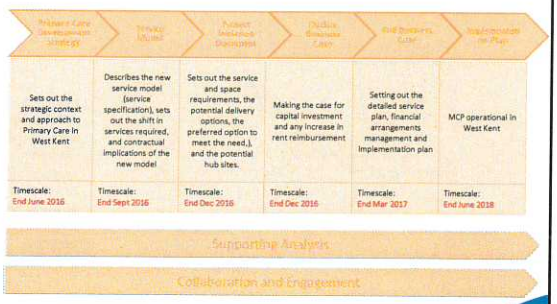
- The Cluster Team **pools the knowledge and care resources** of primary care, community and mental health services, social care, pharmacists and voluntary, community and social enterprise sector partners, to manage the population health of their community.
- They will operate in a single team under the leadership of our local GP's. A team may operate at the level of a large practice, a group of smaller practices, or at a whole locality level. The locality should determine which arrangement works best for them and delivers the greatest improvements.
- Each team will use their combined knowledge and the information about those in their population at greatest risk.
- Informatics tools are available to support this and the aim is to identify the **5% of the population at greatest risk of a health crisis.**
- The Cluster Team will work with each of these people to co-design a **care and support plan** that meets their needs and goals.
- The team will work together to support the delivery of these plans.
- The Cluster Team pools the care resources of primary care, community and mental health services, social care, pharmacists and the voluntary, community and social enterprise sector, to manage the population health of their community
- The Cluster Team will operate in a single team under the leadership of local GP's.
- As a team they will provide enhanced & integrated preventive & proactive care for vulnerable groups of patients - Mental health, End of life, Frail Elderly & LTCs.



The Cluster Team Around The Patient

- Out of hospital care is currently provided in silos with patients often having to attend multiple locations on different occasions to receive their treatment.
- Interagency transaction costs cause delays, expense and poor patient service. Present IT arrangements add to transaction costs.
- We aspire to a create a **network of teams** around the patient (which will serve populations from 30 - 80,000 people depending on geography) whose members manage their patients using all the skills of their colleagues to safely share clinical risk, allow patients to be looked after in their own homes and deliver high quality care. This will require the use of an **shared care record for each team.**
- Since GP systems have records for the entire population served, these will form the basis of this IT. Wherever possible, reporting should be at the level of individual practitioners
- **Team development to enhance working relationships** will be a fundamental part of the new primary care model. The microsystem approach delivers some but not all of this need.
- We need **premises** that will allow these teams to deliver the services described; this might involve a team being housed in a local hub
- Teams will be able to access expertise from secondary care when required, without necessarily having to admit the patient to a hospital bed or to transfer responsibility to secondary care.
- Teams will include GPs, community nurses, specialist nurses, social workers, community mental health workers,
- Pharmacists, therapists and other Allied Health Professionals (AHPs). Almost without exception, there are shortages of each of these professions. Therefore there is a considerable challenge to **recruit and retain this workforce**; the CCG is working to address this.

Developing the Model of NPC



Supporting Strategies & Interdependencies

- Kent & Medway Sustainability & Transformation Plan
- West Kent CCG Operating Plan 2016/17
- West Kent Estates Framework
- West Kent Digital Roadmap
- Quality Improvement Strategy (in production)
- Urgent Care Strategy
- Transforming Outpatients Strategy
- Self Care Strategy
- End of Life Care Strategy
- Dementia Strategy

Emerging CCG Work Programmes

Strengthened General Practice	Developing New Primary Care
Manage demand for general practice services	Mental health provision outside hospital
GP Estate Strategy	Building teams of community and complex care nurses round clusters of practices who serve populations of 30-80k
Disproportionate investment in those practices that face particular problems of demand due to deprivation or high numbers of care home patients	Enhance access to diagnostics
Reduce the complexity of reporting required from General Practice	Specialist Nurses
Develop IT in General Practice	Make every contact count
	Out of hospital bed capacity/Care homes
	Advice from consultants
Strengthen the workforce; recruitment, training and retention	
Working with partner agencies, such as KCC for social care and voluntary sector to create integrated services	

Afterword

- *The NHS is facing some of the greatest challenges in a generation. The population is ageing, more people have long-term conditions, and resources are not keeping pace with demand. Morale amongst frontline clinical staff is an issue and this is leading to problems with recruitment and retention in many areas.*
- *In the face of rising demand and finite budgets, the model of general practice must change if the challenges of preventing ill health, easier access to healthcare and the rising demand of complex technological healthcare are to be met. The Primary Care Strategy tells the 'story' of general practice in West Kent, looks at the challenges ahead and provides a vision for the future. It recognises that the status quo is probably no longer an option.*
- *The strategy discusses initiatives designed to improve provision in a number of key areas and has been designed under the overarching principle of delivering safe and effective health services which patients value and trust. New models of primary care delivery are beginning to emerge across the country and West Kent aspires to be a leader in the delivery of these innovative new models, accepting that there may be slightly different approaches and speed of change in the four localities within West Kent.*
- *Our vision is one where all clinicians will be working in practices that they are proud of, delivering care to patients in wider truly integrated teams.*

Alistair Smith, Lay Chair of Primary Care Co-commissioning Committee

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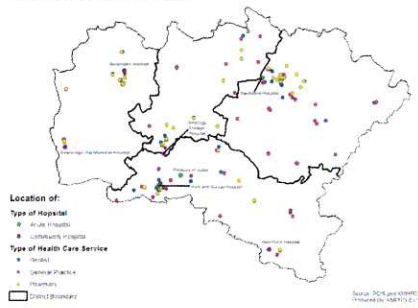
Appendix
Setting the Scene for Primary Care in West Kent

Primary Care Services in West Kent

West Kent CCG primary health care services



The latest information suggests there will be an approximate 20,704 new dwellings built in NHS West Kent CCG (2006-2031).

An Overview of Primary Care in West Kent

- The number of people registered with a GP in the West Kent area was **476,577 patients**, as at 30 September 2015.
- There are **61** general practices located in the NHS West Kent CCG area.
- Operating out of 81 separate premises including branch surgeries
- Across the NHS West Kent CCG area there are **305** individual GPs registered to practice however, a number work on a part –time basis and therefore this equates to **245.2** full time equivalent GPs working in the NHS West Kent CCG area.
- The practice list sizes range from the largest with **19,832** patients and 8.24 FTE GPs to the smallest **1983** patients and 1.67 FTE GPs.
- However those Practices with the 6 largest lists are currently looking after a combined total of **100,000** patients.
- The individual list sizes for GPs range from **2843** to **9831** patients in the West Kent area.
- There are 68 dental practices, 66 community pharmacists and 50 optometrists premises in West Kent

Setting the Scene

NHS West Kent Clinical Commissioning Group (CCG) is made up of the 61 general practices (doctors' surgeries) in the West Kent area and the majority of patients registered with West Kent practices live in the districts of Maidstone, Sevenoaks, Tonbridge & Malling (T&M), and Tunbridge Wells. The exception being Swanley (Sevenoaks district area) whose residents are predominantly registered with practices in the Dartford Gravesham and Swanley CCG area.

The day-to-day work is overseen by a governing body, which is responsible to the GP practices for commissioning the right healthcare services for people in West Kent and ensuring they provide high quality, value for money care.

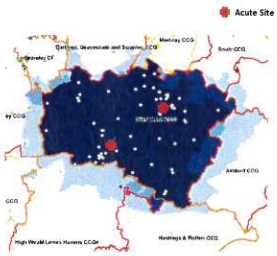
The Governing Body membership comprises 12 GP locality representatives, plus an independent nurse member, an independent secondary care doctor member, a lay member for audit and governance, a lay member for patient and public involvement and the lay chair of the CCG's Primary Care Commissioning Committee as well as the Accountable Officer, the Chief Finance Officer and a Consultant in Public Health. The Governing Body is supported by a number of sub-committees and working groups, including an Audit Committee.

The CCG has an annual budget of £609.8 million to deliver healthcare services for the 480,000 people registered with a GP surgery in the West Kent and those unregistered but resident in West Kent. That equates to around £1,270 per person. The vast majority of the CCG budget was spent on care provided in a hospital setting, other services such as specialised care, the healthy child programme and small elements of primary care (Pharmacy and Optometrists) are paid for by NHS England. Kent County Council commissions public health services, such as sexual health, stop smoking and healthy weight programmes.

Approximate catchment areas of Clinical Commissioning Groups in Kent & Medway

Registered Patient Population:	480,000
Number of GP practices:	61
Neighbouring CCGs	9 8 within the south east region 5 within Kent and Medway 1 within London region
Community Hospitals	4
Acute Hospital (within CCG boundaries)	1 hospital across 2 sites (Maidstone and Tunbridge Wells)

Who We Are



- 480, 000 patients
- 61 practices
- 250+ GPs
- 1 Mental Health site with community facilities
- 2 Acute Hospitals
- 4 Community Hospitals
- 9 Neighbouring CCGs

Our Local Population

Population Demographics

- The age profile of the West Kent CCG population is broadly similar to that of Kent; however, it has slightly lower proportions of people aged 16 and 29, and marginally higher proportions of people aged between 40 and 54 years.
- Population demographics will change significantly over the next 5-20 years, with an increasing ageing population, but also in diversity, particularly in town centre areas. Implications for health, social care and education:
  1. Over the next five years it is estimated that the 85 aged population will increase by 22.4% (2,848 individuals)
  2. Over the next twenty years, there will be a population increase of 19%. The largest increase is expected in the over 65 age band, an increase of 59.4%
  3. Nearly 5% of West Kent CCG population is from non-white background.
- Between mid-2012 and mid-2013, despite some outward migration there was a net increase in migration into West Kent of approximately 10,000 people, of which almost one third was classified as international migration. The majority of this migration appears to be within Maidstone, and the population are most commonly aged between 25 and 49, although there are also a high number of the under 15 population. This potentially indicates that a large proportion of migration will consist of families, however, there could be a possibility of unaccompanied young people.

Deprivation and wider determinants

- Each district within West Kent has areas with poor health outcomes that are also the areas with high deprivation, poor levels of educational attainment, high in fuel poverty, poor air quality and high crime rates. This provides challenges as well as the opportunities for partner organisations to develop collaborative commissioning plans to address wider determinants that affect health outcomes.
- Nationally funded programmes are often available through districts to address the wider determinants, such as Warm Homes for energy [illegible] or Troubled Families programme for families with multiple problems. These programmes, if used effectively can reduce costs [illegible] financial and human terms.

Children and Young People

- Childhood indicators such as infant mortality and low birth weight babies are similar to the Kent average, although there is variation between wards. Breastfeeding at six weeks is higher and smoking in pregnancy is lower than the Kent average. Six wards are among the highest two quintiles of teenage conceptions in Kent: Parkwood, Shepway, Snodland East, East Malling, Sherwood and Trench. Of these six, Parkwood is in the highest quintile.
- More children are placed in KCC (Kent County Council) Foster care in West Kent than the Kent average.
- Sevenoaks has the highest number of children from Irish Traveller and Gypsy Roma communities in Kent, also found to be high in Maidstone.
- The gap in school achievement between those entitled and not entitled to universal free school meals is greater in West Kent than the Kent average, with those in poorer households achieving less in the education arena.

Older people

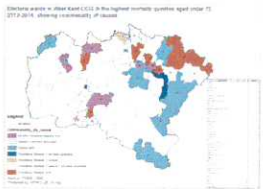
- The highest rate of domiciliary care for people aged over 65 is currently Snodland East and Judd wards (51.3 and 32.4 respectively per 1,000 population). With an expected increase above the Kent average of people over age 85 in Maidstone and Tonbridge and Malling, this picture could change, but will certainly place higher demand on services for both health and social care. In addition there are several wards in West Kent with people over 60 living in deprived households, known to be higher users of services.

West Kent Health Profile Highlights 1

Generally West Kent enjoys good health in comparison to neighbouring geographical areas, but there are still inequalities between areas.

Health Indicators

- Although people in West Kent generally live longer than the rest of Kent, there are still inequalities, in which those in more deprived areas can experience death up to 13.1 years less life than those in more affluent areas.
- Data within this document highlights that within the areas of high deprivation, poor levels of education, high crime rates particularly against the person, housing conditions, homeless people and poorer health outcomes can be found. For example Maidstone has the second highest rates of homeless people in Kent, almost four times the number of people in 2008, usually found within the town centre.



Life Expectancy

- In West Kent life expectancy is higher than for the Kent average (82.7 and 81.7 years respectively). Over the last five years whilst the life expectancy has increased across the whole CCG area, it has increased marginally faster in the most deprived quintile compared to least deprived quintile but there is still a gap of 13.1 years, between the poorest and most affluent areas within the CCG.

Trends in Mortality

- Life expectancy has increased at the average rate of 0.26 years over each two year time period, with marginal increase in the most deprived quintile.
- Mortality rates for under 75 cancer, circulatory and liver disease have decreased, although there has been an increase in under 75 respiratory mortality. The age standardised mortality rate from under 75 liver disease has increased by 1.17 deaths per 100,000 population between 2011-13 and 2012-14.
- Over the most recent recorded ten year period, the average ratio of excess winter deaths in West Kent has remained similar to the Kent ratio (17.4% and 17.5% respectively). This said the West Kent ratio was high in the first five year period, followed by a decrease in the second five year period. Fuel poverty is highest in Tunbridge Wells and Maidstone.

West Kent Health Profile Highlights 2

Diabetes

- Recorded prevalence of diabetes in West Kent CCG is lower than the Kent average, but varies between practices. Recorded diabetes has been increased at a similar rate to the Kent average, and is estimated to continue to do so. There is a moderate association between recorded diabetes and obesity. Additional risks of complications among people with diabetes are higher in West Kent CCG than England and Wales, in particular Heart Failure, Stroke, major and minor amputations and Renal replacement therapy.

Asthma

- Prevalence of asthma in West Kent CCG is similar to Kent (5.6% and 5.5%) but there is variation between practices (ranging between 3.6% to 8.4%). There is no strong correlation between prevalence of asthma and hospital admissions.

COPD

- The prevalence of COPD is below the Kent average (1.49% and 1.8% respectively). Modelling estimates large numbers of undiagnosed cases.

Coronary Heart Disease

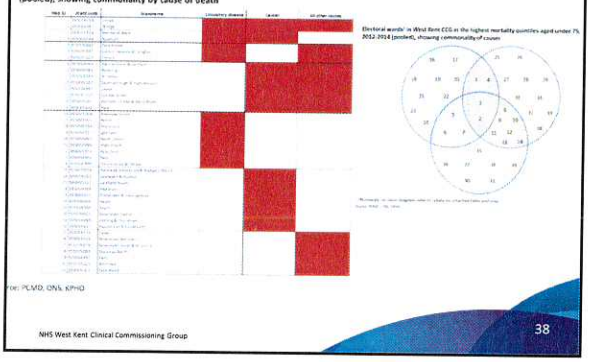
- Prevalence of CHD is lower than Kent and Medway and England, again modelling estimates that prevalence is significantly higher, as with hypertension, with an estimated 6,300 undiagnosed patients.

Cancer

- West Kent CCG has a slightly higher recorded cancer prevalence (2.3%) then both Kent and Medway (2.2%) and England (2.1%). Recorded cancer prevalence ranges from 0.8% to 3.9%. Mortality rates are highest in lung cancer for men, and for women rates are highest for lung and breast cancer.
- 54% of lung cancer admissions are emergencies, whilst only 25% are diagnosed at an early stage.
- An estimated 12,788 people in West Kent are living with and beyond cancer up to twenty years after diagnosis.

Mortality Rates by Ward

Electoral wards in West Kent CCG in the highest mortality quintile, aged under 75, 2012-2014 (pooled), showing commonality by cause of death



ce: PCMD, ONS, KPHO

West Kent Health Profile Highlights 3

Mental Health

- Prevalence is similar to Kent and Medway, and lower than national. Hospital admission rates vary and a number are higher than the West Kent CCG and there is a mild association between prevalence and admissions
- Bridge and Shepway South have the highest contact rates for those aged between 15 and 64 with a mental health condition, although contact rates vary across West Kent CCG from 34.8% to 41.0%
- Emergency admissions for mental illness vary between practices (51.0 to 296.4 per 100,000 population)
- Prevalence of depression is lower in West Kent CCG than in Kent and Medway and England, but there is a variance of 2% to 12.1% between practices
- Suicide rates are similar to Kent, although female are slightly higher. Male rates increase with each age band and peak at 50 to 59, rates then reduce until aged 80 and over. Females remain relatively low and are highest at age 80 and over.

Learning Disability

- Prevalence of patients with learning disabilities is lower in West Kent CCG than in Kent and Medway, and contact rates are highest in Lenham, Park, Bridge and Hildenborough. The overall West Kent CCG contact rate (those in contact with services) for those with mental health learning disabilities is lower than Kent. Detailed analysis also suggests low uptake of annual health checks in some areas.

Dementia

- Dementia prevalence in West Kent CCG is similar to Kent and Medway and England at 0.6%. Referrals into memory assessment clinics continue to increase by approximately 40% per year and emergency admissions with dementia codes as primary or secondary diagnosis have increased by 106.6 per 100,000 population.

Falls

- Hospital admissions due to falls rose steadily until 2011/12 and fell in 2012/13. A small increase occurred in 2013/14 and trend analysis estimates the increase to continue.

West Kent Lifestyle Factors Affecting Health

Alcohol

- Eleven MSOAs* (have an estimated binge drinking prevalence of above 18.9%, all of which are within Maidstone and Tunbridge Wells wards
- The highest numbers of licenced premises in West Kent are restaurants and cafes, most densely found in town centres. Although pictorially there appears to be higher admissions for obesity or alcohol related conditions from these areas, this is more likely to be due to deprivation as analysis shows no correlation

Obesity & Diet

- An estimated 28% of adults are classified as obese within six MSOAs in West Kent: Snodland East and West; Sherwood; Shepway North and South; Parkwood
- Obesity in reception aged children has reduced from 9.4% to 8.2% and has plateaued. Conversely, at year 6 obesity levels have increased from 16.3% to 18.5% between 2013 and 2014. This equates to prevalence of 30% obesity or overweight at year 6. There are variations in prevalence between wards
- Only 15% of residents from eleven MSOAs in West Kent are estimated to consume the recommend five portions of fruit and vegetables a day

Smoking

- Prevalence of smoking is relatively low in West Kent, but seven wards (six of which are in Maidstone) have a prevalence of over 30%

Air quality

- Maidstone has measured some of the highest NO_2 concentrations in Kent, particularly around the route from town centre towards Tovil. The crossroads on Tonbridge Road at Wateringbury also has consistently high recorded levels of NO^2

Sexual Health - Contraception etc

- The uptake of young people's preventative sexual health services is highest in Maidstone
- Abortion rates in West Kent are similar to Kent, but the number of repeat abortions is increasing and is higher than the England average in all CCGs in Kent
- The administration of long acting reversible contraception (LARC) by GP is higher in West Kent than the England average
- Genitourinary Medicine (GUM) clinic attendances are highest in Maidstone, but this is possibly due to the provision of more specialist services at this site. Tonbridge and Malling has the highest number of new appointments. Sevenoaks has the highest number of patients attending out of area services, often in London clinics
- The burden of new Sexually Transmitted Infections (STIs) is increasing in most districts within West Kent, with the exception of Tonbridge and Malling, which was highest in West Kent in 2013 and dropped significantly in 2014
- STIs are highest in those aged 25 and under, but this is expected due to proactive Chlamydia screening
- Maidstone has a higher Chlamydia positivity rate than Kent, although all other West Kent districts were lower
- Gonorrhoea has increased by 2.51% in West Kent, also Genital Herpes 3.56 cases per 100,000 population
- Diagnosed HIV prevalence is lower than Kent in all West Kent districts, but late diagnosis has increased in West Kent between 2009 and 2013

Super Output Areas (SOAs) are a geography for the collection and publication of small area statistics. They are used on the Neighbourhood Statistics site and across National Statistics. There are [illegible] layers of SOA, lower Layer Super Output Area (LSOA) and Middle Layer Super Output Area (MSOA). The SOA layers form a hierarchy based on aggregations of Output Areas (OAs). The MSOA has a minimum population of 5,000 people and 2000 households and a mean population 7,200 and is built from lower Layer SOAs. MSOA also fit within local authority boundaries (a set of [illegible] within a local authority area.