Introduction

I am pleased to present the Annual Public Health Report for 2007. The purpose of the Annual Report of the Director of Public Health is to provide information on the health of the local population; to highlight important public health issues and priorities; and to make recommendations to organisations and people with an interest and responsibility for protecting, promoting or improving health and well-being.

Last year’s report was the first to make publicly available large amounts of data on Kent’s population, and covered many areas, including children, older people, smoking, obesity, sexual health, accidents and the environment. That report, and additional data, is available at the Kent information website: www.kmpho.nhs.uk

We talk a lot about reducing inequalities in health. This report looks at how we are progressing on inequalities in health and highlights how we measure them. In some areas there has been significant progress on reducing inequalities but overall in Kent there appears to be a widening of inequalities for some communities.

This year we are taking the opportunity to look at areas which were only touched upon in last year’s report: health inequalities, mental health, disability, dementia, carers, healthcare acquired infection, immunisation and vaccination, dental health, offender health, maternity services, and climate change, as well as looking at commissioning plans for the future. Recommendations are given at the end of each chapter. Again, data, which cannot be included in this printed report, will be available at: www.kmpho.nhs.uk

I would like to take this opportunity to thank all my colleagues, in the Primary Care Trusts, Kent County Council and the local authorities, for their contributions to this report. Many people have written chapters, offered advice, analysed data and provided administrative and technical support, for which I am grateful.

Meradin Peachey
Kent Director of Public Health
Acknowledgements

**Eastern & Coastal Kent PCT**
- Andrew Scott-Clark  Deputy Director Public Health
- Jonathon Sexton  Assistant Director Public Health
- Stephan Cochran  Public Health Specialist
- Claire Martin  Public Health Specialist
- Sandro Limentani  Assistant Director Public Health
- Lynne Selman  Director of Citizen Engagement and Communications

**West Kent PCT**
- Jessica Mookherjee  Assistant Director Public Health
- Jenny Hall  Specialist Public Health Registrar
- Julie Hunt  Associate Director of Strategic Development
- Farzana Desai  Senior House Officer, Public Health Dentistry
- Julia Ross  Director of Civic Engagement
- Niall Prosser  Emergency Planning Officer

**Kent County Council**
- Ute Vann,  Policy and Strategy Officer, Kent Supporting People Team
- Lesley Andrews  Strategic Head of Commissioning for Adult Services Kent Drug and Alcohol Action Team
- Emma Hanson  Policy Manager, Kent Adult Social Services
- Debra Exall  Head of Performance and Planning, Kent Adult Social Services

**Kent Health Protection Unit**
- Katie Allen  Health Protection Specialist Nurse
- Sheena Fenn  Health Protection Specialist Nurse

**Kent and Medway Cancer Network**
- Fiona Craig  Interim Lead Commissioning Director

**South East Coast Specialised Commissioning Group**
- Brijender Rana  Public Health Consultant
- Nick Haslem  Commissioning Manager

**Kent & Medway Public Health Observatory**
- Declan O’Neill  Head of Kent & Medway Public Health Observatory
- Natasha Roberts  Head of Health Intelligence
- Del Herridge  Public Health Team Manager
- Julian Barlow  Senior Public Health Information Analyst
- Sarah Spencer  Senior Public Health Information Analyst
- Mark Chambers  Senior Public Health Information Analyst
- Kerry Oakton  Public Health Information Analyst
- June Jolley  Public Health Information Analyst
- David Smaldon  Public Health Information Analyst
- Jill Rutland  Knowledge Manager
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Health Inequalities

Introduction

In 2007 the Department of Health published *Tackling health inequalities: status report on programme for action (2007)*, a progress report on the original paper *Tackling health inequalities: a programme for action (2003)*: Two key indicators were developed to monitor the reduction in the health inequalities gap.

- **Infant Mortality**
  - Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole

- **Life expectancy**
  - Starting with local authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole.

This chapter explores the health inequalities within Kent Districts on the basis of deprivation; all cause all age mortality and life expectancy. These are key contributors to the indicators listed above.

Context of Socio-Economic Structure and its Influence on Health

Relative differences in wealth underpin most health inequalities. This lack of access to wealth governs the degree to which the least prosperous are excluded from mainstream society.

International research (Dahlgren and Whitehead 2006) demonstrates that relative deprivation drives the disparity in death rates across the social spectrum. Those with high socio-economic status have the longest average life expectancy, while those with lowest status have the shortest life expectancy, largely due to high rates of premature death (deaths under 75).
Deprivation

Poverty exists all over Kent and is not confined to specific areas. Although the districts of Sevenoaks, Tonbridge and Malling and Tunbridge Wells are the most affluent they contain significant numbers of people who are relatively deprived. Conversely, the more deprived districts, mostly within the east of the county, contain localised areas of affluence. Figure 1 shows the proportion of each district’s population living in relative deprivation and affluence. The population has been divided into three, those living within the 20% most deprived areas, those living in the 20% least deprived areas and those in-between.

Figure 1 Percentages of local population by deprivation quintile

This highlights the major differences in the socio-economic structure of each PCT area. At a glance it can be seen that while approximately a third of the population of NHS West Kent are in the most affluent 20% this only pertains to a tenth of the Eastern Coastal Kent PCT population. Similarly, while only 12% the population of NHS West Kent are in the most deprived quintile this group accounts for a quarter of the Eastern and Coastal Kent PCT population.

At district level the most evenly proportioned population is Dartford and to a lesser extent, Ashford. Districts such as Sevenoaks, Tonbridge and Malling and Tunbridge Wells have populations distributed towards high prosperity. These contrast with many coastal districts where there are very high proportions of people with low socio-economic status. In the latter regard, Thanet, Swale, Shepway, Dover and to a lesser extent Canterbury, are the more notable.
Mortality

Comparisons between the directly age standardised all cause all age mortality rates for the five year rolling periods 1995/99 and 2002/06 have been made to identify whether health inequalities have improved or worsened, for each of the Kent districts, the two PCTs and Kent as a whole.

Figure 2 shows the percentage change in mortality between the 1995/99 and 2002/06, for those in the 20% least deprived areas of a district and those in the 20% most deprived; Mortality in both these groups has decreased. Large reductions in mortality rates were seen in the 20% most deprived areas for Ashford (28.3%), Gravesend (17.6%) and Tunbridge Wells (17.6%). However, populations living in the more affluent areas also experienced a large decrease in mortality rates Dover (25.8%), Shepway (22.3%) and Tonbridge & Malling (19.1%).

Overall for Kent the mortality rates in the most prosperous areas are declining at a slightly more rapid rate that those in the most deprived areas. In consequence the health gap has widened slightly for Kent as a whole.

Beneath this headline trend there are marked contrasts at district level. There is a narrowing health gap within the overall population served by Eastern and Coastal Kent PCT reflected in converging trends in Ashford (a remarkable reduction in the mortality rate for the most deprived albeit from a high starting point) and in the Borough of Swale. Reductions can also be seen in the boroughs of Dartford and Gravesham.

Of real concern are the divergent trends and therefore widening health gaps. These are to be found within the West Kent PCT area. The greatest increase in the health gap anywhere in Kent is to be found in Tonbridge and Malling. Increases are also noted in Maidstone and Sevenoaks. In the coastal districts of east Kent, large increases can also be seen in Shepway, Thanet, and Dover. A modest divergence has taken place in Canterbury.
Life Expectancy

Figure 3 shows that at county level life expectancy is increasing at similar rates between the two quintiles, with the deprived sector demonstrating slight improvements relative to the affluent sector in percentage change. This trend is also visible for east Kent where life expectancy in the bottom quintile increased at a greater rate than the top quintile. In terms of actual years of life expectancy, the affluent quintile is still increasing the gap compared to the deprived. Overall, people in the more affluent areas of Kent would be expected to live nearly five years longer than people resident in the more deprived areas.

Figure 3 Percentage change in Life expectancy at birth in Kent, comparing levels for 1995-1999 with 2002-2006 by deprivation status and area of residence.

Figure 4 Life Expectancy in years, 20% most deprived and 20% most affluent, districts 1995/99 and 2002/06
It is evident that much of the increased life expectancy in the most deprived quintile can be attributed to substantial life gain in Dartford, Ashford and to a lesser extent in Gravesham and Swale. Most other areas show a divergence in life expectancy between the deprived and the better off. In every local authority area, life expectancy is higher for the affluent compared to the most deprived. In every instance (except Sevenoaks), life expectancy is increasing. The more affluent districts tend to have higher life expectancy than more deprived areas. In 1995-99 even the most deprived quintiles in Sevenoaks and Tonbridge and Malling had a higher life expectancy than the affluent in Dover but this situation has changed for the later period 2002-06.

**Discussion**

These trends reflect similar patterns reported nationally by the Scientific Reference Group to oversee Tackling Health Inequalities: A Programme for Action (see for example the report for 2007).

Recent NHS policy (Choosing Health 2004, South East SHA Health Inequalities Action Plan 2007, High Quality Care for All 2008 [Darzi Review] and to some extent Health Inequalities Progress and Next Steps 2008) has focused on what Scott-Samuel (2008) describes as superficial health inequalities, those directly created by public institutions, such as inequalities in access to NHS care. Inequalities in individual diseases are also more straightforward. Investing in stop-smoking services and cervical cytology services, targeted in poorer areas, will certainly reduce overall cancer prevalence and also reduce inequalities in these diseases. There is, however, a continuing and, some would argue, undue focus on individual responsibility to avoid chronic disease through healthy living. This approach is wholly appropriate for a large majority of society, but manifestly unfair on those with the least resources and ability to make appropriate lifestyle changes.

It has to be stressed that the overall impact on health inequalities of NHS measures will be limited by the effects of “competing risks of death”, meaning that if downstream risks and diseases are addressed, rather than their “upstream” socio-economic, or socio-political causes; other risks would simply take their place. Eliminating smoking would mean that poorer groups would continue to die (slightly less prematurely) but from other causes which would increase their relative importance.

The only way to effectively address health inequalities is to tackle root causes which ultimately are to do with poverty. What is needed is a social model of health approach which is in part currently addressed through the Kent-wide Health Inequalities Action Plan 2007 and local action plans for each health and well-being group/health action team in district council areas. However, the World Health Organisation is publishing this year its definitive internationally based report (chaired by Sir Michael Marmot) on the social causes of ill health. This should prompt a reassessment and revision to the Kent Public Health Strategy.

Whilst the main initiatives for change can only be taken by central government, there continues to be a role for both the Kent Partnership and Local Strategic Partnerships in addressing these divergent local trends and developing strategies to reverse them using a social model of health approach and focusing on employment opportunities and anti-poverty measures.
Introduction

One in four people in England and Wales will have some form of mental illness over their lifetime (Singleton et al 2002) and as a result mental health was chosen as one of the six national priorities for the Choosing Health white paper (2004). The socio-economic and environmental factors associated with poorer mental health are social stigma, stress, worry, entrapment, fear and isolation (Singleton and Lewis 2003).

There are broadly two approaches to estimating the numbers of people with mental health problems in the general population. One is relevant to the types of common problems, such as depression and anxiety, for which people commonly consult their GPs. The other relates to the more severe types of problem, such as schizophrenia or manic-depressive illness for which people use specialist services. Much of the data used in this section are from the national Psychiatric Morbidity Survey applied to the Kent population.

Social and economic risk factors

People at greatest risk of mental health problems include people living in areas of deprivation, from Black and Minority Ethnic (BME) groups (particularly people from Black African and Caribbean origin), people who are unemployed, homeless and/or in poor quality housing, and refugees and asylum seekers.

Deprivation and Unemployment

Being in a lower social class is associated with an increased risk of schizophrenia, delayed recovery and a poorer response to treatment. Social deprivation is also identified as a risk factor in anxiety and depression. Although Kent is a relatively affluent county, it has areas of significant deprivation. The two most deprived wards in Eastern and Coastal Kent PCT are Margate Central and Cliftonville West in the Thanet local authority area which rank 63 and 118 out of 7969 wards in England (1 being the most deprived ward). In West Kent PCT, the most deprived wards are Park Wood in Maidstone local authority area and Northfleet North in Gravesham local authority area (ranked 957 and 1004 respectively) (DCLG 2007). The areas in Kent with higher than national unemployment rates are Gravesh aprm, Swale, Shepway and Thanet.
Ethnicity
People from some BME populations have worse mental health outcomes than the host population but it is hard to uncouple the relationship between mental ill-health, ethnicity and deprivation. In Kent, although the average rate of unemployment is only 1.6%, the unemployment rate for non-white working age adults is 13% higher (Nomis/ONS 2003).

Black African and Caribbean people are six times more likely to have a psychotic illness than other groups and their illnesses are more acute, on seeking care, than other populations. Access to psychological help and counselling services by people of BME origin has traditionally been a problem in England.

In Kent, only 4.7% of the population (64,400 people) are classified as “non-white”. Of this “non white” population, 41% are Asian or Asian British. The districts with the highest ratio of Asian Indians are Gravesham (7.1%) and Dartford (2.1%). (ONS 2008). Data from the Asylum Team within KCC Social Services tell us that numbers of asylum seekers are decreasing.

Homelessness
In 2005/2006 there were 1,669 homeless families in temporary accommodation (a fall of 277 from the previous year). Overall in Kent, 0.31% of households are classified as homeless (a decrease of 14% since 2004/2005). The local authority with the highest rate of homelessness is Dartford (0.75%).

Common Mental Health Problems
The overall prevalence of common mental illness (CMI) in Kent is lower than the England average (Figure 5). In Kent, only Thanet has a higher than national prevalence of CMI. The next highest prevalence occurs in Dartford and Gravesham. However, both nationally and throughout Kent, the prevalence of CMI is high. The prevalence of CMI varies between local authorities and PCTs will need to ensure that access to primary care therapy is available according to need (Figure 6). There are an estimated 133,764 people with a common mental illness in Kent. Eastern and Coastal Kent PCT has an estimated 71,363 people with CMI and there are 62,401 in West Kent PCT (Singleton et al 2002).

Figure 5 Estimated prevalence of common mental health problems (neurotic disorders) in Kent compared with England

Source: Glover (2008)
Major Mental Illness

Major mental illness refers to psychosis and bi-polar disorders and its prevalence is considered to be roughly stable across most population groups and cultures. Around 0.5%-1% of any population will have a psychotic illness. The standardised mortality ratios in schizophrenia are 2.5 times those of the rest of the UK population. It is likely that 15% of those with long-term illness will die due to suicide. Fifty per cent of all acute admissions to psychiatric wards are for schizophrenia, which clearly demonstrates the importance of this condition for the health service.

Personality Disorder (PD) is a term for a person’s abnormal way of responding to personal and social situations, which often results in considerable distress e.g. addictions and obsessions. Although PD is not a mental illness in the sense that schizophrenia and depression are a high proportion of people with PD also have mental health problems. There are almost 5000 people in Kent estimated to have a major mental health problem (not including personality disorders).

Table 1 Estimated prevalence of major mental health problems in Kent

<table>
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<tr>
<th>Diagnosis</th>
<th>England rate per 1000 population</th>
<th>Kent</th>
<th>West Kent PCT</th>
<th>Eastern &amp; Coastal Kent PCT</th>
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<tr>
<td>Paranoid PD</td>
<td>7</td>
<td>6969</td>
<td>3352</td>
<td>3617</td>
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<tr>
<td>Schizoid PD</td>
<td>8</td>
<td>7965</td>
<td>3831</td>
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<td>Antisocial PD</td>
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<td>5973</td>
<td>2873</td>
<td>3100</td>
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<tr>
<td>Borderline PD</td>
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<td>6969</td>
<td>3352</td>
<td>3617</td>
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<tr>
<td>Dependent PD</td>
<td>1</td>
<td>996</td>
<td>479</td>
<td>517</td>
</tr>
<tr>
<td>Compulsive PD</td>
<td>19</td>
<td>18916</td>
<td>9099</td>
<td>9817</td>
</tr>
<tr>
<td>Psychosis</td>
<td>5</td>
<td>4978</td>
<td>2394</td>
<td>2583</td>
</tr>
</tbody>
</table>

Source: ONS Psychiatric Morbidity Survey (Singleton et al 2002) applied to local populations
Major mental health problems, commonly associated with use of specialist care, show a greater degree of concentration in areas of social deprivation (Glover 1999). In order to account for social deprivation, an index called the MINI2K was created and the distribution of major mental illness in Kent, based on scores from this index, is shown in Figure 7.

**Figure 7** Distribution of major mental illness in Kent

Suicides in Kent & Medway

Kent and Medway NHS and Social Care Trust, undertook a full retrospective suicide audit in 2006.

The audit found that since 2004,

- The rate of suicide and open verdict per 100,000 population in Kent and Medway has fallen from 10.4 per 100,000 to 9.4 per 100,000 in 2006.
- In 2006 77% of the 151 suicides and open verdicts recorded in Kent and Medway were male,
- 35% were in contact with mental health services 12 months before their death and
- of those in contact with mental health services prior to suicide, 72% were males.

Since 2001, Suicides and open verdict deaths involving persons in contact with mental health services in Kent and Medway ranged from a low of 2.5 per 100,000 in 2002 to a high of 4.4 per 100,000 in 2004. The rate in 2006 was 3.3 per 100,000

The rate of suicide and injury undetermined differ between the three PCTs. (Eastern & Coastal, Medway and West Kent) The rate of suicide and injury undetermined in West Kent PCT peaked in 2002/04 (8.92 per 100,000 population) and is currently experiencing a downward trend as is Eastern & Coastal Kent PCT, Medway however is experiencing an increase. For the period 2004/06 Eastern & Coastal Kent PCT have a rate (8.79) higher than that for England (8.25), the other PCTs are below the rate for England.(see Figure 8).
The main method of suicide is hanging (for males) and self poisoning (females). The majority of deaths by suicide and open verdict in Kent and Medway occur to males between 34-54 years old, white, employed and with families. Out of all those deaths where suicide or open verdict was recorded, 70% had no diagnosis of mental distress/illness. Of those where there was a diagnosis, the vast majority were linked to depression and anxiety disorders (20%). It is apparent, from this data, that depression and anxiety in white males must be taken seriously in Kent and better mental health awareness, promotion and intervention is needed.

**Future Needs Assessments**

A comprehensive Mental Health needs assessment is planned for completion in 2008. This will include further information on incidence and prevalence as well as data from current mental health services. A detailed assessment of data provided from Kent and Medway PCTs including information on service delivery can be found at http://www.nepho.org.uk/mho/workbook.php.

**Recommendations:**

- Complete a comprehensive needs assessment; commissioned 2008
- Ensure there is a clear mental health promotion strategy (agreed with local authorities) for each PCT in Kent.
- Complete an audit of provision of access to psychological therapies and primary care interventions to ensure equity of services.
- Ensure that users and stakeholders are involved in development of services.
Dementia

Dementia is a progressive and largely irreversible clinical syndrome that is characterised by a widespread impairment of mental function. Symptoms may include memory loss, language impairment, disorientation, changes in personality, difficulties with activities of daily living, self-neglect, psychiatric symptoms and out-of-character behaviour. As the condition progresses, people with dementia can present carers and social care staff with complex problems including aggressive behaviour, restlessness and wandering, eating problems, incontinence, delusions and hallucinations, and mobility difficulties that can lead to falls and fractures (NICE 2006). Dementia is one of the main causes of disability in later life (Institute of Psychiatry 2007).

The main types of dementia are: Alzheimer’s disease, vascular dementia, fronto-temporal dementia, dementia with Lewy bodies and mixed dementia. Alzheimer’s disease is the most frequently occurring dementia. Dementia results in increasing levels of disability and dependence for those with the condition.

Dementia is principally a disease of the elderly affecting 6% of people over the age of 65 years and 30% of people over the age of 90 years. (BMJ Publishing Group 2008) In the next 10 years, the number of people aged over 65 will increase by 15% and the number of people aged over 85 will increase by 27%. We are therefore likely to see a significant increase in the incidence of age-related mental health problems.

Mortality and morbidity

People with dementia have markedly decreased survival rates compared with those without dementia and are two to four times more likely to die at a given age than those of the same age without dementia. Even mild cognitive impairment is associated with the increased relative risk of mortality. (Xie et al. 2008)

The proportion of deaths attributable to dementia increases steadily from 2% at age 65 to a peak of 18% at age 85-89 in men, and from 1% at age 65 to a peak of 23% at age 85-89 in women. Overall, 10% of deaths in men over 65 years, and 15% of deaths in women over 65 years may be attributable to dementia. Annually, 59,685 deaths among the over-65s might have been averted if dementia were not present in the population. The majority of these deaths occurred among those aged 80-95 years. Delaying the onset of dementia by five years would halve the number of UK deaths due to dementia to 30,000 a year (LSE/Institute of Psychiatry 2007).
Services for dementia have traditionally been seen as “Cinderella” services but this has begun to change and a number of national publications have begun to raise the profile of dementia.

The Department of Health has just launched ‘Transforming the Quality of Dementia Care: Consultation on a National Dementia Strategy’ (2008), which seeks to address three key themes:

- Improving awareness of dementia, both among the general public and among health and social care professionals
- Ensuring that the condition is diagnosed as early as possible to allow for early intervention; and
- Delivering a high quality of care and support for both those with dementia and their carers.

**Prevalence of Dementia in Kent**

Population projections both nationally and locally predict an inevitable rise in population numbers, with the elderly population increasing the most. The local population is set to grow by 7% across all age groups by 2017 and by 14% by 2027. The over-65s population will increase by 18% within the next decade and by 32% over the next 20 years. Over-65s currently account for 17% of our local population; this will rise to 21% in 2017 and 23% in 2027. Highest proportionate increases in persons aged over-65 will take place in East Kent local authority areas such as Ashford, Swale and Shepway.

Such increases in elderly population size will in turn result in an increase in the numbers suffering from dementia. Over the next 20 years it is projected that national prevalence figures will increase by 61% giving a total of 937,636 people aged over 65 with dementia. Application of these national prevalence figures to the current and projected local population enables us to approximate local numbers of dementia sufferers both now and in the future.

In Kent there were an estimated 18,377 dementia sufferers over the age of 65 in 2007. In line with projected population growth, this figure will rise by 3,800 (21%) by 2017 and 10,826 (59%) by 2027.

**Prevalence of Dementia in local authorities and PCTs in Kent**

Projected numbers of dementia sufferers vary between local authority and PCT areas in Kent in line with their respective population projections. The highest numbers of elderly dementia sufferers are found in Canterbury, Thanet and Maidstone local authorities, although this is only a symptom of there being larger elderly populations in these areas. Tonbridge and Malling local authority will experience the highest rate of growth by 2017 with numbers of elderly dementia sufferers rising by 32% over the next decade, whereas Swale local authority will experience the largest increase over the next 20 years, with numbers rising by 81% in this time.

Eastern and Coastal Kent PCT area has a larger population of elderly and larger numbers of dementia sufferers than in West Kent PCT area. However, rates of increase in the elderly population will be greater in West Kent in the coming decade, rising by 23% in this time. By 2027, the overall increase in the number of people with dementia will be 58% in West Kent PCT area and 60% in Eastern and Coastal Kent PCT area.
The South East Coast Strategic Health Authority has recently commissioned work to support the development of clinical metrics for dementia (2008).

This work has enabled a set of metrics to be produced in a visual format to compare needs and service provision across the health economy. This information will help to inform future commissioning of dementia services.

**Service Costs of Dementia**

The service costs associated with dementia are far higher than all other mental health conditions put together. They currently make up 66% of all mental health service costs; by 2026 it is estimated that they will make up 73% of all mental health service costs (at 2007 prices).

The elements used by the King's Fund to estimate total costs for dementia were: in-patient care; other NHS services; supported accommodation; day care; other social services; and informal care. Together these suggest that the average annual cost of dementia care is £25,472 per person. The total cost of dementia care in England in 2007 is estimated to be £14.8 billion. Assuming that service costs will increase by 2 per cent ahead of inflation each year, and given the aging population and the rising cost of care, this is projected to rise to £34.8 billion by 2026: an increase of 135 per cent.

Most care for dementia takes the form of social care, residential care and informal care from family members.
Figure 10 Distribution of Service Costs for Dementia

Source: Kings Fund (2008)

Given the major cost impact of dementia, which underlies much of the estimated increase in mental health costs by 2026, health professionals, and in particular GPs, should make it a priority to establish better systems of early detection and treatment for dementia, and pharmaceutical companies should maintain their efforts to develop cost-effective treatments that will help people remain independent for as long as possible.

Recommendations

• In line with national policy, emphasis needs to be placed on diagnosis and early intervention, with a comprehensive strategy setting out training needs of GPs and a range of other health care professionals
• More emphasis will need to be placed on early interventions and greater investment must be put into preventative services.
• Early interventions that are known to be cost effective need to be commissioned across Kent to improve the well-being of our older people with dementia.
Disabilities

The Disability Discrimination Act (DDA) (2005) defines a disabled person as someone who has a physical or mental impairment, which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.

Disability may occur at birth as a genetic condition, as a result of an accident or a result of ill health. A person’s disability needs to be considered when providing healthcare services and health promotion materials. Understanding the needs of all groups within our population enables us to work towards reducing health inequalities.

Social Model of Disability

The UK Council of Disabled People defines the social model of disability as a clear focus on the economic, environmental and cultural barriers encountered by people who are viewed by others as having some form of impairment - whether physical, sensory or intellectual. This model is entrenched in the new Disability Discrimination Act 2005 (amending the 1995 Act), which is enforceable by law. This is not just about adapting buildings so that wheelchair users have access, important though that is. It is also about ensuring, for example, that people with communication difficulties (whether through learning disabilities, mental health problems, sensory impairment or a combination of these) are supported to make their views known and to understand what is being conveyed to them.

A key issue for many disabled people with mobility problems is getting to hospital appointments, GP surgeries or community pharmacies if there is no suitable or accessible public transport.

Health inequalities in relation to disabled people

The health of disabled people in Kent is poorer than that of the general population. Some of this is due to their primary disability but much of it is avoidable and can and should be addressed. Some work is being undertaken in Kent to address this health inequality but there is more that needs doing.
For people with learning disabilities there is national evidence that the health inequality they experience has a profound effect on their life expectancy. They are

- less likely to access routine screening
- experience ‘diagnostic overshadowing’, where physical ill health is viewed as part of the learning disability and therefore not investigated or treated.
- 58 times more likely to die before the age of 50
- 4 times more likely to have a preventable cause of death

(Hollins et al 1998).

With the increasing awareness of personal rights, better advocacy and improving access to health services there has been a significant rise in their life expectancy in recent years, but it is still below that of the general population. This continues to be a major issue for many people with disabilities, and their families and carers.

An example is the extremely low number of women with learning disabilities who attend cervical smear tests. Anecdotally people are not invited, or not supported by their carers to attend, because of issues or anxiety around communication and consent. Many of these judgements are made on an ad hoc basis and outside the framework of the Mental Capacity Act (2005). Typically people feel they are acting in the best interests of the women, but it is not acceptable that collectively we let a higher proportion of women with learning disabilities die of a preventable disease.

Many people with learning disabilities find arranging appointments with their GPs difficult. Some surgeries rely on telephone booking, and a common issue is the lack of disability awareness training amongst reception staff. An example of how a GP could make an appointment more accessible is by booking a double appointment so that more time could be taken to explain problems adequately. Work has been done by some self-advocacy services in training some GPs and their staff in parts of the county. There is also informal information sharing as to who are the most learning disability-friendly GPs. This is a natural response but a system that relies on who you know to get the best out of it, is one that still has some way to go. These issues are being tackled by the Good Health Group in Kent, building on the Service Framework ‘Management of Health for People with Learning Disabilities in Primary Care (NHS Primary Care Contracting 2007). In 2008 each PCT is recruiting a Primary Care Facilitator to implement the Framework. In addition Eastern and Coastal Kent PCT is recruiting three facilitators to work alongside primary care to support this, and a Practice Development Nurse for acute hospitals to implement the anticipated recommendations of the ‘Death by Indifference’ report (Michael 2008). There has also been other work into communication aids for primary care and hospitals, and training for GPs by people with learning disabilities.

For people with sensory disabilities, there are problems with communication. Access to interpreters can be limited, and there have been appalling examples of deaf people having to rely on their children to communicate with their GP or hospital consultant.

- 15% of deaf people (30% of British sign language (BSL) users) avoid visiting their doctor because of communication problems, and
- 35% of deaf people leave their GP unsure of what is wrong with them.
- 42% of deaf people (66% of BSL users) who visited a hospital (non-emergency) found it difficult to communicate with NHS staff.
- 70% of BSL users admitted to accident and emergency units were not provided with an interpreter (RNID 2004).

Adult Social Services has funded staff to accompany and sign for people as otherwise they will not attend appointments. There needs to be a more coherent response across the county to this specific need.

People with autism also have significantly poorer health outcomes, particularly with respect to their mental health needs. In some cases professionals dispute a person’s primary need and cannot respond to the person appropriately or to address their needs. For people with Asperger’s syndrome or high functioning autism, this may be even more profound as they do not fall neatly into any categories, unless their mental health needs have become very acute. The personal cost to these individuals and their families can be enormous.
It is also a very inefficient use of public funds, as addressing the needs when they have become acute, is significantly more expensive than preventative input.

Access to dentistry is an issue for people from all categories of disability. Many have no access to NHS dentists and as a group are significantly less likely to have the financial capacity to access private care than the general population. As a group they are more likely to suffer the effects of poor dental hygiene with its long-term effect on both their teeth and their general health.

There are significant public health challenges in relation to people with disabilities. Because of the life-long nature of many disabilities, people and their families become experts by experience. The single most useful way that services can improve to better meet people’s needs, is to listen to them.

**Prevalence of disability**

Estimating the prevalence of those with a disability is problematic. A number of people living with a disability may not consider themselves to be, as it’s a state of acceptance, ‘just the way it is’. There is no systematic recording of individuals with a disability; the council holds a voluntary register and children are recorded as having a special educational need (SEN)

Adults living with a disability are able to claim a number of benefits; this data provides us with a good estimate of the number of adults (18+) who are living with a disability. In November 2007 there were 47,950 adults in Kent claiming disability living allowance, which is the best overall indicator of severe and ongoing disability, but there are many people with impairment who will not qualify for this allowance.

The 2001 Census identified the number of Kent people (aged 16-64) who were “not in good health” as 48,140. The Census also provided evidence of the close correlation between those “not in good health” and those in group 4, the lowest socio-economic group (see Figure 11).

**Figure 11** Proportion of reported ‘Not good health’ as at 2001 census, by age group.
Of course many disabled people are in good health, such as someone with Down’s syndrome or a visual impairment would not include themselves in this category.

In 2007, 3,415 people with learning disabilities were known to Kent Adult Social Services (rising to 3,546 in 2008), and 372 to the NHS. This roughly corresponds to an estimate (Parrott 1997) that 0.45% of the 18-74 population has severe and profound learning disabilities, which equates in Kent to 4,111 people. However, the total number of people with learning disabilities, (including mild and moderate) is estimated nationally (Department of Health 2001) to be 2.5% (22,837 adults in Kent).

**Physical disabilities** are caused by a wide range of conditions, such as cystic fibrosis, cerebral palsy, spina bifida, multiple sclerosis, although some people with these conditions in a mild form would not consider themselves disabled. Physical disabilities can also be caused by accidents: indeed this is the most common cause of physical disability in younger adults.

To give an indication of the incidence of profound physical disability in Kent, Kent Adult Social Services provides support to some 2,970 people with physical disabilities.

**Sensory impairment** also affects a significant proportion of the population, with an estimated 53,500 under-60s in Kent having some degree of hearing impairment (2,031 with severe or profound deafness), and 11,300 under-65s in Kent having a visual impairment. Amongst the over-65s the incidence is much greater.

- An estimated 22,900 people in Kent have visual impairment and
- 211,400 have some degree of deafness (22,600 severe or profound).
- 1,400 people known to KCC with combined deafness and sight impairment, a little less than the national projections of 1,800.
It is well understood that sensory impairment is much more common in older people. Perhaps less well understood is the association between sensory impairment and other disabilities. For example, at least one in three people with learning disabilities will also have a serious sight loss, and there is considerable evidence showing that more profoundly learning disabled people have a very high incidence of poor visual acuity and ocular health problems (McCulloch et al 1996). Deafness is also common in people with learning disabilities - it is estimated that 10% have significant hearing impairment or deafness, prevalence 100 times that of the general population (Miller and Courtenay 2006).

It is estimated that up to 40% of deaf and hard-of-hearing people experience a mental health problem at some point in their lives, sometimes caused by communication and language problems during childhood.

Autistic spectrum disorders (ASD) affect 1% of the population, which equates to 13,000 people in Kent. From 1987 improved diagnosis of ASD was developed and mainly applied to children. Those children are now becoming adult, and are presenting a new set of challenges to adult services. A KCC select committee on autism has been established and will report early in 2009, from which we will need to develop more appropriate cross-agency support arrangements.

Finally, it is worth noting that the incidence of many disabilities is rising because of improved medical care and hence improved survival rates. Certainly the numbers of young people with profound and complex needs moving from children's services to adult services is rising every year, even though school rolls are falling.

Personalisation and rising expectations

The philosophy espoused nationally in Our Health Our Care Our Say (Department of Health 2006) and Putting People First (Department of Health 2007), and locally in Vision for Kent (Kent County Council 2006) and Active Lives (Kent County Council 2007), is to ensure disabled people have choice and control over how they live their lives by giving them the power to develop their own support package, through Direct Payments or Individual Budgets. We are still in the early stages of this shift of power which is already, quite rightly given the points made above, increasing disabled people's expectations of services. There is evidence that personalisation enables disabled people to take greater responsibility for themselves, including their health.

Impact on carers

Many disabled people have families or friends who provide care for them (see the separate chapter on carers). There is a clear correlation between the disabled person's health and their carer's health.

Disabled children

There is currently no single data source that encompasses all disabled children in Kent. Current thinking is that around 7% of the child population falls within the definition of 'disabled', and that 1.16% of children fall within the autistic spectrum.

There are currently 2,750 children on the Kent County Council's Children's Disability Register, although this is a voluntary and self-defined register. Nearly 13,000 0-18 year olds in Kent were identified as having a limiting long-term illness (4.3%) in the 2001 census. Almost one quarter (50,000) of school pupils are identified as having some form of additional need. Of these, just under 6,300 pupils (2.8%) in January 2007 had a statement of Special Educational Need.
Table 2 Estimated number of children with disability

<table>
<thead>
<tr>
<th>District</th>
<th>Estimated No. of 0-18 year olds in 2006. Source: KCC</th>
<th>No. of disabled children and children with long term conditions based on the new 7% figure (Council for Disabled Children 2006)</th>
<th>No. of children with a condition on the autism spectrum. Based on the new 1.16% figure1(Baird et al 2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashford</td>
<td>27,600</td>
<td>1932</td>
<td>320</td>
</tr>
<tr>
<td>Canterbury</td>
<td>30,400</td>
<td>2128</td>
<td>352</td>
</tr>
<tr>
<td>Dover</td>
<td>25,100</td>
<td>1757</td>
<td>291</td>
</tr>
<tr>
<td>Shepway</td>
<td>22,100</td>
<td>1547</td>
<td>256</td>
</tr>
<tr>
<td>Swale</td>
<td>30,800</td>
<td>2156</td>
<td>357</td>
</tr>
<tr>
<td>Thanet</td>
<td>31,100</td>
<td>2177</td>
<td>360</td>
</tr>
<tr>
<td>Dartford</td>
<td>22,200</td>
<td>1554</td>
<td>258</td>
</tr>
<tr>
<td>Gravesham</td>
<td>23,600</td>
<td>1652</td>
<td>274</td>
</tr>
<tr>
<td>Maidstone</td>
<td>33,800</td>
<td>2366</td>
<td>392</td>
</tr>
<tr>
<td>Sevenoaks</td>
<td>26,000</td>
<td>1820</td>
<td>302</td>
</tr>
<tr>
<td>Tonbridge &amp; Malling</td>
<td>28,900</td>
<td>2023</td>
<td>335</td>
</tr>
<tr>
<td>Tunbridge Wells</td>
<td>26,200</td>
<td>1834</td>
<td>304</td>
</tr>
<tr>
<td>Eastern and Coastal Kent PCT</td>
<td>167,100</td>
<td>11,697</td>
<td>1,936</td>
</tr>
<tr>
<td>West Kent PCT</td>
<td>160,700</td>
<td>11,249</td>
<td>1,865</td>
</tr>
<tr>
<td>KCC area</td>
<td>327,800</td>
<td>22,946</td>
<td>3,801</td>
</tr>
</tbody>
</table>

Throughout 2007, significant advances were made in the continued drive to modernise both health and social care services for disabled children and children with complex health needs in Kent. This agenda is shared by KCC Children, Families and Education Directorate, Kent and Medway NHS and Social Care Partnership Trust, Eastern and Coastal Kent PCT, West Kent PCT and the voluntary and community sector. Our objective is for children, young people and their parents and carers to be at the heart of this modernisation.

Table 3 Referrals to KCC Disabled Children’s Service over a 12 Month period

<table>
<thead>
<tr>
<th></th>
<th>Mar 07</th>
<th>May 07</th>
<th>Jul 07</th>
<th>Sep 07</th>
<th>Nov 07</th>
<th>Jan 08</th>
<th>Mar 08</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>KCC exc. Asylum</td>
<td>1,011</td>
<td>954</td>
<td>1,030</td>
<td>843</td>
<td>850</td>
<td>863</td>
<td>796</td>
<td>10,222</td>
</tr>
<tr>
<td>Disability East</td>
<td>17</td>
<td>25</td>
<td>22</td>
<td>16</td>
<td>2</td>
<td>12</td>
<td>13</td>
<td>174</td>
</tr>
<tr>
<td>Disability West</td>
<td>10</td>
<td>11</td>
<td>28</td>
<td>12</td>
<td>24</td>
<td>18</td>
<td>13</td>
<td>204</td>
</tr>
</tbody>
</table>

The key national guidance specifically for disabled children and those with complex health needs is contained within the National Service Framework for Children, Young People and Maternity Services (Standard 8)(Department of Health/Department of Education and Science 2004):

“Children and young people who are disabled or who have complex health needs receive co-ordinated, high quality child and family-centred services which are based on assessed needs, promote social inclusion and where possible enable them and their families to live ordinary lives.”
The Vision is that:

- Children and young people who are disabled or who have complex health needs, should be supported to participate in family and community activities and facilities.
- Health, education and social care services should be organised around the needs of children, young people and their families, with co-ordinated multi-agency assessments leading to prompt, convenient, responsive and high quality interventions that maximise the child's ability to reach his or her full potential.
- Children and young people and their families should be actively involved in all decisions affecting them and in shaping local services.

2007 saw the opening of a new Children's Assessment Centre in Canterbury, the first full year's operation of the Sunrise Children's Resource Centre in Tunbridge Wells, and the development of the Windchimes Children’s Resource Centre in Herne Bay. These all evidenced a significant investment in new resources for this group of children and young people. The resource centres are the result of a reconfiguration of ‘short break’ services, bringing residential and community based services together, operating on a ‘hub and spoke’ model. The ‘spokes’ reach out into local universal services such as children’s centres and family centres in the centres’ catchment areas. Windchimes was developed as a partnership project between all key stakeholders, including children and their parents. Social care and nursing staff work alongside each other to provide overnight stays for a range of disabled children and young people, including those with complex health needs.

A new government initiative, ‘Aiming High for Disabled Children - Better Support for Families’, was published in May 2007, and seems set to have a significant impact on the shaping and provision of services over the next five years. It proposes a guaranteed service for disabled children encompassing five key elements;

- Access to information
- Transparent levels of support
- Participation by children and families in the planning, commissioning and delivery of services
- Integrated assessment processes
- Feedback: clear and published complaints procedures for families

As part of the ‘Aiming High’ initiative, the Government committed funding from the 2008-11 comprehensive spending review for the transformation of the provision of short breaks. Local Authorities and their PCT partners were invited to bid for pathfinder status under a transformation programme. Kent County Council and its PCT partners have successfully bid to become one of the pathfinders, bringing in an additional £15m of investment to transform short breaks for disabled children over the next three years. A delivery plan for Kent has been submitted to the Department for Children, Schools and Families.

For very young disabled children, 2007 saw early support starting across Kent following a successful piloting programme. For young people, aged 14 and over, significant progress was made toward the goal of every disabled young person having a person-centred transition plan in place, to support them in the process of becoming young adults.

A direct payment advisory service was commissioned by KCC to provide advice and support to parents, carers, and young people, over 16, wishing to manage their own support needs through the use of a direct payment.

Further progress was made towards a person-centred assessment of needs and care planning process, with local authority occupational therapists being integrated into KCC social work teams.

Recommendations

Implement, as a Kent-wide priority the:

- Framework for Management of Health of People with Learning Disabilities in Primary Care (NHS Primary Care Contracting 2007)
- Valuing People Better Health Action Plan (Department of Health 2001)
- Improve access to interpreting services for deaf people
- Increase the numbers of disabled people able to register with NHS dentists
- Develop a robust protocol for supporting people with Asperger's syndrome and high functioning autism to ensure they access primary care appropriately. The select committee on autism should pave the way for this.
- Strengthen mechanisms to seek the views of disabled people about services
- Develop and agree care pathways, where these are not yet in existence, for people with specific impairment.
Alcohol

Introduction

Despite some evidence of the beneficial aspects of moderate alcohol intake, the impact of alcohol on well-being can also bring about a wide variety of negative consequences, which seem to exceed these benefits. In England 38% of men and 16% of women aged 16-64 years have an alcohol use disorder, amounting to approximately 8.2 million people (Kent County Council 2008).

In terms of social well-being, excess alcohol consumption and alcohol misuse:

- Can harm home life, marriage, work, studies and friendships and lead to child neglect, physical abuse and sexual abuse.
- is related to lower levels of productivity and reduced employment.
- can result in intentional and unintentional injuries.
- is thought to be associated with a about half of all incidents of domestic violence
- Drink driving is still responsible for 7% of all accidents and for 17% of all deaths in road accidents in the country.
- Is a factor in approximately 35% of all A&E attendances and ambulance calls in the UK.
- 150,000 hospital admissions each year are alcohol-related, of which about 33,000 are due to liver diseases. The actual overall number of alcohol specific hospital admissions in Kent has almost doubled from 885 admissions in 1997-8 to 1,454 in 2006-7.

The rate of hospital admissions for alcohol specific conditions in the under 18s in Kent varies throughout the districts. The highest rates are seen in Thanet, 114 per 100,000 population, this compares to Tunbridge Wells were the rate is 29 per 100,000 population.
Incidence of cirrhosis of the liver has increased dramatically. It is estimated that 4,500 deaths in England and Wales every year are associated with alcohol-related liver diseases – 90% more than the last decade. In 1970 England had a death rate of 2 per 100,000 population, seven times lower than the European average at the time. Figures for 1998 show a rate of 7 per 100,000 in England, whereas the EU average has declined to below 10 per 100,000. (Department of Health 2001)

Between 15% and 25% of suicides, and 65% of suicide attempts in England, are related to problem drinking. Links can be found between alcohol misuse and anxiety and sleep disorders, depression, alcohol dependence, nerve damage, brain damage and cognitive impairment. Research also shows that alcohol misuse can negatively affect pregnancies and can result in unsafe sex and unintended teenage pregnancy.
Health Inequalities and Alcohol

Alcohol addiction is a “family illness”, as the family organises its life around the misuser. Almost 1 million children in the UK currently live in households with parents misusing alcohol. Children whose parents suffer from alcoholism are six times more likely than other children to experience verbal and physical aggression, sometimes on a daily basis.

In Kent it has been estimated that substance misuse (both for alcohol and drugs misuse) is a parental characteristic of over half the children (56.1%) on the child protection register. Over 800 children are currently on the protection register in Kent.

What we are doing

Alcohol treatment has continued to develop across the county, with a widening availability of access to low threshold brief interventions.

The number of adults in Kent undergoing treatment for alcohol misuse more than doubled from the period 2005-6 to 2006-7. Similarly, the number of young people in treatment increased from 115 in 2005-6 to 271 in 2006-7.

The KCC Alcohol Select committee reported at the end of 2007 on both the extent of alcohol related harm in the country and also on the action that was needed to address those harms, in line with the national ‘Safe Sensible Social’ (Department of Health/Home Office 2007) drinking strategy. The committee has adopted the key themes of this strategy and will be combining them with local knowledge and best practice in the forthcoming year through the development of an associated action plan.

Figure 15 Percentage of contacts receiving alcohol interventions, adults and children, Kent 2007

Recommendation

- Facilitate the implementation of the Select Committee Action Plan, which will identify measures to improve services for alcohol misusers.

Cirrhosis mortality rates increased steeply in Britain during the 1990s. Between the periods 1987-1991, and 1997-2001, cirrhosis mortality in men in England and Wales rose by over two-thirds (69%) and in women by almost half (44%). These relative increases are the steepest in Western Europe, and contrast with declines in most other countries, especially those of southern Europe. (Leon and McCambridge 2006)
Drugs

Introduction

It is acknowledged that illicit drug use is responsible for harm, not only to the individual but also to the family and general population, with drug related activity causing widespread distress to others. A high proportion of acquisitive crime has been driven by the need to subsidise drug misuse, and criminality around drug distribution can have a damaging impact on communities, as drugs and supply structures provide momentum for crime and anti-social behaviour.

Health Inequalities and Drug Misuse

There are a large number of risk factors, some related to health inequalities, which may promote drug misuse, such as extreme economic deprivation, lack of community cohesion, behavioural problems, lack of family support, lack of educational attainment, alienation, and early peer rejection (NCCDP 2008).

What we are doing

There is a substantial body of evidence, which shows that a choice of treatment intervention is effective in reducing the harm that substance users inflict on themselves and others. The political agenda has supported this by promoting treatment services over a number of years.

There is now a full complement of drug treatment services across Kent and focus has been on the integration of these services into a whole systems framework to reduce attrition, maximise frontline resources and improve retention and engagement of service users. The commissioning arrangement between Kent County Council and the Kent PCTs is regarded nationally as an example of good practice in the drug sector. This joint investment continues to enable the deployment of resources to where the need is highest within the drug treatment system in Kent.
The largest proportion of service users are in the age group 25 – 34 (43%) followed by 35 – 44 year olds (28%). Over 70% of the treatment population is male, and 93% of service users are white British. The primary problematic drug of choice is heroin, used by nearly 60% of service users. Kent has exceeded the National Treatment Agency annual target of 3542 for numbers in treatment, with year-end performance for 2007/2008 at 3629.

Effective Treatment

Effective treatment is defined as

- Retained in treatment for 12 or more weeks
- Subject to planned discharge following successful completion of treatment within 12 weeks of triage date.

The number of service users in 'effective treatment' (HM Treasury 2007) in drug services across Kent increased by 23.2% in 2007, compared to data from 2006/2007. This percentage increase compares favourably with the rest of the South East.

There has been significant improvement in performance against the national waiting times target of 83%. At the end of 2007/2008, 89% of individuals waited 3 weeks or less for the first intervention and 89% waited 3 weeks or less for subsequent interventions.

Prescribing Services

In 2007 there were 39 GP practices involved in shared-care and 48 pharmacy-based supervised services in West Kent, with 38 GP practices and 84 pharmacies offering supervised services in East Kent.

Harm Reduction

Syringe (Needle) exchange is now an accepted part of the UK response to the prevention of blood borne virus transmission. The syringe exchange scheme in Kent remains successful via 35 community pharmacies, fixed site syringe exchanges and outreach staff. Approximately 700,000 syringes were distributed in 2007 and the return rate was over 70%, above the national average, with over 3000 individuals accessing syringe exchange facilities across the county.
As part of the strategy for controlling the spread of blood-borne virus, syringe exchange and safer injecting advice and information are priorities, though the range of testing interventions for drug misusers and particularly injectors is variable and requires improvement. There is only one on-site phlebotomy testing service in Kent, and of 42 individuals tested in 2007, 12 were Hepatitis C positive. The Health Protection Agency estimates (2007) that Kent has a ‘medium’ prevalence of Hepatitis C of between 25% and 50%, among injecting drug users.

Integrated Drug Treatment System

The introduction of the Integrated Drug Treatment system (IDTS) in 5 Kent prisons has increased the range of treatment options available for drug misusing offenders, notably substitute prescribing. Within IDTS, clinical and psychological treatments have been integrated into one system, in line with the National Treatment Agency ‘Treatment Effectiveness Strategy’ (2005), and working to the standards set by the ‘Models of Care’ (National Treatment Agency 2006). Prison and community treatment are also being integrated within the IDTS framework, to prevent damaging interruptions to the treatment journey, and to improve retention in treatment after release.

Drug Interventions Programme

The Drug Interventions Programme (DIP) is a key part of the Government’s strategy for tackling drugs and reducing crime. The programme aims to move adult drug misusing offenders out of crime and into treatment and other support.

The Home Office visit to Kent DIP in June 2007 identified substantial gaps in the delivery of DIP and performance against the Home Office key performance indicators. A number of proactive measures have been taken to address access to DIP at the point of arrest. The monthly national target of 35 service users in treatment has been exceeded on a monthly basis, and performance is still being improved upon.

Recommendations

- Increase the number of GP shared-care places to ensure specialist prescribing services are accessible for those who require more intensive interventions.
- Improve access to on-site hepatitis testing and vaccinations.
- Continue to improve performance throughout DIP and ensure the service is fully integrated with IDTS and the community treatment system to maximise benefits for offenders requiring access to drug treatment.
Offender Health

Ensuring all offenders receive, and have access to, high quality health and social care services at all stages of the criminal justice system is essential to improving health, tackling inequalities and reducing re-offending.

Nationally, 90% of offenders entering prison have mental health or substance misuse problems, and these problems are also common to many offenders serving community sentences. With many also socially excluded in society, it is imperative that agencies work together to use the opportunity to work with this usually hard to reach group, and make sure that the needs of offenders are identified and that care is tailored to meet their individual needs.

Offenders in Custody

Analyses of health needs of offenders in prison settings show that these needs are significant, particularly around drugs misuse, mental health and the growing elderly population with long-term conditions.

Kent has seven prisons, three in the West Kent PCT area (HMPs Blantyre House, East Sutton Park and Maidstone), and four in the Eastern and Coastal Kent PCT area (HMPs Canterbury, Elmley, Standford Hill and Swaleside). During 2007 all these prisons were subject to a health needs assessment. Their population size and category are shown below. There are many health related issues within the prison estate and this section will concentrate on the key issues.

Table 4 Prison numbers and category

<table>
<thead>
<tr>
<th>PRISON</th>
<th>NUMBERS(M/F)</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMP Blantyre House</td>
<td>122 (M)</td>
<td>C/D</td>
</tr>
<tr>
<td>HMP East Sutton Park</td>
<td>100 (F)</td>
<td>Open</td>
</tr>
<tr>
<td>HMP Maidstone</td>
<td>589 (M)</td>
<td>C</td>
</tr>
<tr>
<td>HMP Canterbury</td>
<td>284 (M)</td>
<td>C (foreign nationals)</td>
</tr>
<tr>
<td>HMP Elmley</td>
<td>985 (M)</td>
<td>B</td>
</tr>
<tr>
<td>HMP Standford Hill</td>
<td>484 (M)</td>
<td>D</td>
</tr>
<tr>
<td>HMP Swaleside</td>
<td>773 (M)</td>
<td>B</td>
</tr>
</tbody>
</table>

Source: Kent PCTs Prison HNA 2007
Inequalities in the Prison Population

Figure 17 Prison population by ethnic group

As can be seen from the above graph, there is a greater representation of black, Asian and mixed ethnic origin in the prison population than in the overall Kent population.

Communicable Diseases

The 1997 survey carried out by the Public Health Laboratory Service and the Prison Service to find out the prevalence of blood borne virus infections and risk factors found that one in four adult male prisoners engaged in activities that put them at risk of infection with HIV/AIDS, Hepatitis B or Hepatitis C. A high proportion of prisoners also engage in risky sexual behaviour. Rates of HIV/AIDS range from 0.26 – 2%, Hepatitis B from 8 – 31% and Hepatitis C from 9 -39%.

Smoking Cessation

Smoking cessation courses are delivered by healthcare and PCT staff in line with the smoking policy at the prisons in compliance with smoke free legislation.

In Kent prisons, the number of prisoners who smoke, ranges from 48% to 85% of the total prison populations. Numbers wishing to quit range from 20% to 85%, however actual quitter numbers are low. The development of a smoking cessation strategy for both prisoners and staff, in association with the PCTs, could significantly improve this number.

Substance Misuse Services

HMP Elmley provides detoxification programmes and also serves HMPs Standford Hill, Swaleside, Maidstone and Rochester. Patients are assessed by the Elmley Detox (Integrated Drug Treatment system) Team, a specialist service which supports prisoners through detoxification. During a 10-month period in 2007, the Elmley Detox Unit assessed an average of 310 prisoners a month. Of these, an average of 90 a month commenced detoxification treatment. An average of 108 prisoners a month entered harm reduction sessions, covering advice and information, including overdose prevention, and sometimes relaxation and acupuncture.

There are discussions taking place between the PCTs, HM Prison Service and KDAAT (Kent Drug and Alcohol Action Team) regarding future commissioning arrangements to include appropriate detoxification needs assessments.
The additional service provided for addictions in HMPs East Sutton Park, Elmley, Maidstone, Standford Hill and Swaleside is provided by specialist drug workers and is not a healthcare function. This service is known as CARATS (Counselling, Assessment, Referral, Advice and Throughcare Services).

Alcohol Misuse

Alcohol misuse is recognised as an influencing factor in the behaviour of many prisoners in the community and has detrimental effects on health. A policy for treatment of prisoners with alcohol misuse problems has been developed, in line with policy in each prison. CARATS currently incorporate alcohol awareness into the in-cell work-packs and one-to-one motivational work. The skills and strategies discussed in the relapse prevention group are applicable to alcohol misuse. Alcoholics Anonymous (AA) is due to be introduced and will be led by managers responsible for reducing re-offending.

Mental Health

Mental health services are commissioned by Medway PCT, on behalf of all the Kent and Medway PCTs. Current mental health in-reach services are provided by the Kent and Medway NHS and Social Care Partnership Trust, via the Kent Forensic Psychiatry Service and the mental health prison in-reach service. In 2007 the Partnership Trust published a “Study to Undertake a Mental Health Needs Assessment Across Kent and Medway Prison Estate” (Harding et al 2007).

Some 18 recommendations were made and these will be used to review the current service level agreement in place between relevant commissioners and providers.

Key Recommendations for prison health

- Prisons should adopt the Health-Promoting Prison strategy, supported by investment to ensure that health promotion and health education are carried out in a proactive rather than reactive manner and that a whole prison approach to health promotion is adopted.

Offenders with a Community Sentence

Nationally, much is known about the health of offenders in the prison system, but very little is known about the health of offenders serving community sentences. Furthermore, offenders on community sentences are more likely to be local, whereas the population of many of our prisons is from outside Kent. However what is known about offenders in the community, from a recent pilot health needs assessment (Brooker et al 2008), is:

- Community offenders are four times more likely to die prematurely than the general male population
- Drugs and alcohol were a factor in almost half the deaths of community offenders
- Half of offender deaths occurred within 12 weeks of release
- The health of offenders is significantly worse than that of the general population.

This section provides an analysis of anonymised self-reported health data, captured through the Kent Probation OaSys system. Kent Probation is a criminal justice agency and part of the National Offender Management System (NOMS). It is the organisation that works with offenders in the community. The aim of the service is to reduce crime and protect the public. The probation service supervises offenders in the community, which includes those people subject to a community order, and those people released on licence from prison.

It is important to note that the data is captured through self-report and it is known that some offenders are reluctant to share their health details with probation staff. Nevertheless, this adds to our picture of the overall health needs of offenders.

The analysis below is a snapshot in time and represents the cohort of offenders in contact with the Kent Probation service in May this year. The sample is 4,298 offenders of which 87.6% are male and 12.4% are female. The service has a number of offices around Kent attended by offenders resident in the local area.
Demographic breakdown

Table 5: Age and sex breakdown of all offenders* on probation in Kent

<table>
<thead>
<tr>
<th>Probation Office</th>
<th>Female 18-29</th>
<th>Female 30-49</th>
<th>Female 50+</th>
<th>Male 18-29</th>
<th>Male 30-49</th>
<th>Male 50+</th>
<th>Total 18-29</th>
<th>Total 30-49</th>
<th>Total 50+</th>
<th>Total People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashford</td>
<td>9</td>
<td>19</td>
<td>1</td>
<td>26</td>
<td>105</td>
<td>85</td>
<td>16</td>
<td>236</td>
<td>236</td>
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<td>Canterbury</td>
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<td>157</td>
<td>127</td>
<td>30</td>
<td>314</td>
<td>349</td>
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<tr>
<td>Dover</td>
<td>12</td>
<td>19</td>
<td>1</td>
<td>32</td>
<td>92</td>
<td>103</td>
<td>21</td>
<td>216</td>
<td>249</td>
<td></td>
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<tr>
<td>Folkestone</td>
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<td>20</td>
<td>3</td>
<td>40</td>
<td>135</td>
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<td>22</td>
<td>277</td>
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<tr>
<td>Gravesend</td>
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<td>7</td>
<td>98</td>
<td>283</td>
<td>250</td>
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<td>209</td>
<td>64</td>
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<td>Medway</td>
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<td>3</td>
<td>64</td>
<td>261</td>
<td>277</td>
<td>56</td>
<td>594</td>
<td>658</td>
<td></td>
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<tr>
<td>Sheerness</td>
<td>13</td>
<td>6</td>
<td>1</td>
<td>22</td>
<td>52</td>
<td>48</td>
<td>17</td>
<td>116</td>
<td>137</td>
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<tr>
<td>Sittingbourne</td>
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<td>13</td>
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<td>35</td>
<td>94</td>
<td>98</td>
<td>22</td>
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<td>56</td>
<td>201</td>
<td>170</td>
<td>38</td>
<td>410</td>
<td>479</td>
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<tr>
<td>Tunbridge Wells</td>
<td>19</td>
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<td>2</td>
<td>40</td>
<td>171</td>
<td>147</td>
<td>40</td>
<td>358</td>
<td>398</td>
<td></td>
</tr>
<tr>
<td>Kent</td>
<td>232</td>
<td>265</td>
<td>36</td>
<td>653</td>
<td>1758</td>
<td>1832</td>
<td>376</td>
<td>3765</td>
<td>4298</td>
<td></td>
</tr>
</tbody>
</table>

* All Offenders currently on probation as of May 2008

Overall the majority of offenders (90%) are in the 18-49 age range, this percentage varies across the county from 85% to 96%. Analysis of individual years shows that the number of offenders generally decreases with age.

Health Inequalities in Offenders with a Community Sentence

Health Care access

Offenders find accessing health services difficult, particularly dental and mental health services, and are therefore more likely to use accident and emergency services. This is compounded by a number of offenders who are known to move frequently around the county.

Accurate registration information for these offenders is not known, and therefore it is difficult to currently assess how their overall health needs are being met.

Drugs misuse

Overall the percentage of positive responses for drug misuse among offenders on probation is fairly consistent across Kent, ranging from 53% in Sheerness to 63% in Thanet, Folkestone and Medway. The reported Kent average for offenders reporting a drug misuse problem is 60%.

Self Reported Health Problems

Self-reported health problems varied across Kent probation offices, from 33% in Gravesend and Folkestone to 47% in Sheerness. The percentage for Kent, as a whole, means that more than 1 in 3 offenders have a perceived physical or mental health condition.

Self Harm

Self reported thoughts about suicide or self harm in offenders across Kent varied by office, from 16% in Sheerness to 31% in Tunbridge Wells.
Alcohol Misuse

The percentage of offenders who reported ‘some/significant problems’ with alcohol use varied across the county from 28% in Sheerness to 53% in Tunbridge Wells.

Psychiatric Problems

The percentage of offenders with a current psychiatric problem across Kent varied from 13% in Ashford to 24% in Tunbridge Wells. Approximately 1 in 6 offenders have a psychiatric problem although only 1 in 16 have a significant psychiatric problem.

Kent Probation report that offenders with mental health problems have difficulty accessing community-based local mental health services.

Characteristics of the community-based offender population are:

- Average of 60% self-reported drugs misuse
- 37% of the offenders reported perceived health problems
- 23% reported self-harm or suicidal thoughts
- 39% self-reported alcohol problems
- 17% reported psychiatric problems with 6% reporting significant psychiatric problems.

Recommendations

- Eastern and Coastal Kent, Medway and West Kent PCTs should undertake jointly a complete health needs assessment of the community offender population, and this should be overseen by, and reported through, the Kent and Medway Offender Health Partnership
- Kent Probation should record GP and dental registration status for all offenders attached to their service.
- Alongside the needs assessment, models and pathways of care should be developed and commissioned, especially those relating to community-based offenders with mental health problems.

The Kent prison population has four key features: it is largely young, overwhelmingly male, has an over-representation of ethnic minorities, and has a very high turnover. Prisoners are drawn from lower socio economic groups and have poor levels of education.
Immunisation and Vaccination

Improving the uptake of immunisation and vaccination in more deprived areas is one way of reducing infant mortality and thus improving health inequalities.

Vital in this work is providing effective ante-natal care, including screening and immunisation, and promoting effective education about ways to improve health, of which immunisation plays an important part.

Childhood Immunisation Programme

The overall aim of the routine childhood immunisation programme is to protect all children against the following preventable childhood infections:

- diphtheria
- tetanus
- pertussis (whooping cough)
- *Haemophilus influenzae* type b (Hib)
- polio
- meningococcal serogroup C (MenC)
- measles
- mumps
- rubella
- pneumococcal.
The national schedule for routine immunisations recommended by the Joint Committee for Vaccination & Immunisation (JCVI), a national expert committee, is given Figure 18. Primary immunisation with diphtheria, tetanus, pertussis, polio and Hib (DTaP/IPV/Hib) vaccine is given at two, three and four months of age. Pneumococcal vaccine is given at two and four months. MenC vaccine is given at three and four months. This ensures completion of the primary course at an appropriate age to provide protection against infections such as whooping cough, pneumococcal, Hib and meningococcal serogroup C, which are most dangerous for the very young. The DH target is to immunise at least 95% of eligible children.

PCT Performance

Immunisation uptake for diphtheria, tetanus, polio, pertussis, Hib, for children reaching their second birthday in 2007/08 for Eastern and Coastal, and Medway PCTs exceeded that for the SHA and West Kent PCTs. For Men C the uptake for all three PCTs was better than that for the SHA and for England.

Quarterly trends of coverage for DTaP/IPV/Hib at 24 months [Figure 19], show that the trends have remained consistent since October 2005. However West Kent experienced a decline in the uptake of the vaccine April 2007. The rate for West Kent has been increasing steadily since this period and is now in line with the other PCTs.

Source: www.hpa.org.uk – COVER data
Measles, Mumps and Rubella

In 2007/08, 86% of children reaching the age of 2 had been immunised against measles, mumps and rubella with the combined MMR vaccine, in Eastern and Coastal Kent. The uptake was worse in West Kent 82% [Table 6]. The national rate during this period was 85%. Elsewhere, 35 PCTs reported uptake of 90% or above, although none were greater than 95%. 105 PCTs reported uptake below 90%, of which 22 had uptake of 80% or less. The coverage rate has increased considerably in the past two years, now that parental confidence has returned following previous adverse publicity. This is part of a national trend and it is anticipated that performance will continue to increase in the coming months.

Data on the use of single vaccines is not collected. As a result the proportion of children fully or partially protected against measles and rubella may be slightly higher than that identified by COVER, Cover of Vaccination Evaluated Rapidly.

Meningitis C (MenC)

In 2007/08 96% of children had been immunised by their second birthday, in Eastern and Coastal Kent and 94% in West Kent. These figures are higher than national rates (92% and 93%).

Table 6 2007/08 COVER statistics percentage uptake of childhood vaccinations by 24 months

<table>
<thead>
<tr>
<th>Organisation</th>
<th>(DTaP/IPV/Hib)</th>
<th>MMR</th>
<th>Men C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern and Coastal Kent</td>
<td>95</td>
<td>86</td>
<td>96</td>
</tr>
<tr>
<td>West Kent</td>
<td>93</td>
<td>82</td>
<td>94</td>
</tr>
<tr>
<td>South East Coast</td>
<td>93</td>
<td>83</td>
<td>92</td>
</tr>
<tr>
<td>England</td>
<td>94</td>
<td>85</td>
<td>93</td>
</tr>
</tbody>
</table>

Immunisation at age five

The reported uptake for diphtheria, tetanus and polio suggests that 86% of children have received their primary course and booster by the age of 5, in Eastern and Coastal Kent and 83%, in West Kent. This compares to 78% nationally. The uptake for 1st and 2nd doses of MMR by age 5 is 78% in Eastern and Coastal Kent and 72% in West Kent. The national rate was 74%.

Table 7 2007/08 COVER statistics percentage uptake of childhood vaccinations by the Childs 5th birthday

<table>
<thead>
<tr>
<th>Organisation</th>
<th>(DTaP/IPV/) Booster</th>
<th>MMR 1st and 2nd Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern and Coastal Kent</td>
<td>94</td>
<td>86</td>
</tr>
<tr>
<td>West Kent</td>
<td>94</td>
<td>83</td>
</tr>
<tr>
<td>South East Coast</td>
<td>91</td>
<td>78</td>
</tr>
<tr>
<td>England</td>
<td>93</td>
<td>78</td>
</tr>
</tbody>
</table>

Vaccination and Immunisation Rates by GP Practice

Analysis of returns for vaccination and immunisations by practice shows variation with some practices achieving 100% vaccination rates whilst others are as low as 50%. There may be a problem with the quality of the reporting data, but assuming it is an accurate reflection of vaccination rates, additional support should be given by the PCT to those practices where rates are low in order to increase rates. The reasons for the variation are not known for certain but may be a combination of factors, including organisational factors within primary care, and an increase in families whose first language is not English and who are not accessing preventive health services to the same degree.

BCG

The BCG vaccination programme is targeted at those individuals who are at greatest risk. The programme identifies and vaccinates babies and older people who are most likely to catch the disease, especially those living in areas with a high rate of TB or whose parents or grandparents were born in a TB high prevalence country. In the PCT area 123 BCG vaccinations were administered to infants aged under one year.

The significant decline in the number of skin tests and BCG vaccinations since 2005/06 is due to the introduction of the new BCG vaccination programme from September 2005 which replaced the programme delivered through schools with a more targeted vaccination programme.
Seasonal Flu

All those in whom the disease is more likely to be a serious illness should be offered flu immunisation, i.e. all people aged 65 years and over, those with chronic respiratory or heart disease, renal disease or diabetes mellitus, those who are immunocompromised, and those living in long stay residential accommodation. Complications such as bronchitis and pneumonia are more common in those with underlying diseases, especially if they are also elderly, and related flu deaths are almost entirely in these groups. In long-stay residential accommodation influenza immunisation prevents rapid spread of infection causing outbreaks with high morbidity and mortality.

It is also appropriate to immunise frontline health care workers against flu to ensure that services for patients are maintained. Immunising health care workers is part of prudent winter planning for the NHS. It ensures they do not pass on flu to their patients, but should also help the NHS maintain staffing levels during a flu epidemic when both GPs and other health services are particularly busy and hard pressed.

In order to increase uptake this year, GPs and primary care trusts have been set targets for immunisation among the 65 years of age and over group. This year we are aiming to reach an overall national uptake of 70% in those aged 65 and over. The strongest influence on whether people are immunised or not is whether their doctor or nurse has recommended it. Nationally there have been advertising campaigns targeted at people in the recommended groups and their carers. Figure 20 shows the coverage for the last two years.

Figure 20 Percentage uptake of Influenza Vaccination in those aged 65 and over, Kent PCTs, SHA and England 2006/07 and 2007/08
Human Papilloma Virus (HPV)

The government has announced the introduction of a human papilloma virus (HPV) immunisation programme starting in September 2008. The programme will involve the routine vaccination of girls aged 12–13 years against cervical cancer. There will also be a two-year catch-up campaign, starting in Autumn 2009, for girls aged up to 18 years.

Currently in England there are about 2,200 cases of cervical cancer a year, with about 800 deaths. HPV causes 99 per cent of invasive cervical cancer, and it is estimated that HPV vaccines could reduce the number of cases by 70 per cent.

Following advice from the JCVI, the cervical screening programme will continue after the HPV vaccination programme has been introduced. This is necessary because the vaccine does not protect against all HPV types that may cause cervical cancer.

Local Implementation

Community Services are creating a vaccination team integrated with School Health. Staff are currently being recruited and plans for their training are in place prior to starting the school programme. Premises are being arranged. The Team is also planning additional clinics to cover those young people not in schools or missed for some other reason.

Recommendations

- The PCTs should continue to work with primary care teams to ensure high rates of vaccination and immunisation are continued, particularly ensuring that vulnerable groups are also included in the programmes.

- The seasonal flu campaign to protect the vulnerable, health care workers and poultry workers continues to be important to protect against endemic disease and to reduce the potential threat of a pandemic.

- The new HPV vaccine programme should be fully implemented to reduce the incidence of cervical cancer among women.
Healthcare Associated Infections

What are healthcare associated infections (HCAI)?

These are infections acquired as a result of healthcare interventions, usually occurring in a hospital setting. However, this is not always the case and people can acquire these infections whilst undergoing treatment in general practice, mental health trusts, care homes, ambulances and even their own home, if undergoing clinical treatment. (Department of Health 2008)

Monitoring of HCAI

“The importance of HCAIs as a cause of preventable illness and death has been recognised increasingly in recent years, and the prevention and control of these infections has become a priority. Surveillance and monitoring of these infections is key to their control: we need to be able to measure them if we are to assess whether any impact has been made on controlling infection. Many hospitals in the country have participated in voluntary surveillance of key infections for many years. However, as part of the increased focus on control of HCAI, surveillance of some infections was made mandatory. This started off with *Staphylococcus aureus* (including methicillin resistant Staphylococcus aureus, MRSA) bacteraemia in April 2001 and was later extended to glycopeptide resistant enterococcal bacteraemia in October 2003, *C. difficile* associated disease in January 2004.” (Health Protection Agency 2008)

South East Cost has set a target of zero incidences of MRSA for all PCTs to achieve.
This information is available to all acute trusts and the Kent Health Protection Unit, all of whom monitor the data carefully to identify whether there are increases in case numbers or trends occurring.

All acute trusts in Kent have worked very hard using the Department of Health guidance and implementing different strategies to reduce the incidence of HCAI within their hospitals; this work is borne out in the data below initially for Methicillin Resistant Staphylococcus Aureus and then C. difficile.

The data presented for each bacterium are comparison graphs between Kent, the Strategic Health Authority (SHA) and England. The SHA for Kent is South East Coastal SHA, which covers all of the Kent, Medway, Surrey and Sussex acute trusts.

The ‘Kent’ figure is the aggregate of the three Acute Hospital Trusts:

- Dartford & Gravesham NHS Trust,
- East Kent Hospitals NHS Trust and
- Maidstone & Tunbridge Wells NHS Trust.

In order to make comparisons between the Kent aggregate and the average across South East Coast SHA and England, the figures for MRSA and Clostridium difficile have been shown as a rate per 10,000 occupied bed days. This is the total number of beds occupied by patients in the acute hospital trust at a set time each day, usually midnight, over the course of the year.

**Methicillin Resistant Staphylococcus Aureus (MRSA)**

Figure 21 shows that the number of MRSA bacteraemias in the SHA increased year on year from 2002/2003 where the number was 1.84 cases per 10,000 bed days to a peak in 2005/2006 of 2.12 cases per 10,000 bed days since then there has been a dramatic decrease down to 1.33 cases per 10,000 bed days.

**Figure 21 Trends in MRSA rates**

![Figure 21 Trends in MRSA rates](source: Health Protection Agency)
When mandatory surveillance was commenced in April 2001, Kent had higher numbers of MRSA bacteraemias than both the national and Strategic Health Authority (SHA) average for the years 2001/2002, and 2002/2003. Since then there has been a steady decrease in MRSA bacteraemias from 1.67 cases per 10 000 bed days down to 0.98 cases per 10 000 bed days in 2007/2008. These figures mean that in 2001/2002 in Kent there were 185 MRSA bacteraemias recorded, whereas in 2007/2008, this figure had fallen to 83. This equates to a 55% reduction in the number of cases. Since 2003/2004 the Kent average number of MRSA bacteraemias has been consistently below the national and SHA average.

The Department of Health, in the 2008 revision of the Health Act, has stated that all trusts in England must commence MRSA screening of all patients coming in for elective admission, this includes patients being admitted for day-case treatment or investigation. There are likely to be exclusions to this guidance, and clarification from the Department of Health is awaited. The implementation of this guidance should be complete by March 2009. The next stage is the screening of all elective and emergency admissions and this should be in place by 2010/2011.

**Clostridium difficile**

Since January 2004 there has been mandatory reporting of all positive laboratory isolates of *C. difficile* in patients over the age of 65 years to the Health Protection Agency (HPA) who collate the data, produce statistics, and quarterly and annual reports: These are available from the HPA website: [www.hpa.org.uk](http://www.hpa.org.uk)

Figure 22 is a comparison of rates for *C. difficile* per 1000 bed days, for patients aged 65 and over, between Kent hospitals, the SHA and England. The rates for *C. difficile* are expressed per calendar year rather than financial year as in MRSA bacteraemias. The reason for the difference in period is that MRSA surveillance commenced on 1st April 2001; therefore the data is collected in a financial year period whereas *C. difficile* surveillance commenced on 1st January 2004 and thus uses the calendar year for data presentation.

**Figure 22 Trends in *C. difficile* rates**

![Graph showing trends in Clostridium difficile rates](source: Health Protection Agency)
In 2004 Kent had a slightly higher rate than the combined average of trusts in Surrey, Sussex, Kent and Medway and of all trusts in England, with 2.27 cases per 1000 bed days. However, since 2004, the rate in Kent has been consistently lower than the SHA, which saw a rise from 2.19 cases per 1000 bed days in 2004 up to 2.61 cases in 2006, with a decrease to 2 cases per 1000 bed days in 2007. The rates of *C. difficile* in Kent were steady for the three years 2004 – 2006 at about 2.27 cases, however in 2007 there was a dramatic drop in cases to 1.29 per 1000 bed days. This equates to a fall of 557 cases from 1284 in 2006 down to 727 in 2007, a fall of 43% in one year.

The above data relates to cases in the population aged 65 years and above, and includes specimens taken from people in hospital as well as those from the community. From 1st January 2008 a second cohort of people have been included in mandatory surveillance, aged 2 to 64 years.

Figure 23 Compares MRSA and *C difficile* rates using information taken from national tables published by the Health Protection Agency in July 2008. The *C difficile* rate per 1,000 bed days is displayed on the central vertical axis and the MRSA rate per 10,000 bed days on the horizontal axis. The two axes cross at values representing the national average MRSA and *C difficile* rates.

East Kent Hospitals University NHS Trust is represented by the red data point in the lower left quadrant. Both the MRSA and *C difficile* rates corrected for bed numbers, are well below the NHS average.

Figure 23 *C difficile* rate compared with MRSA rate per 10,000 bed days, acute trusts and teaching hospitals 2007-08
What are we doing?

The Healthcare Commission carried out an inspection following the *Clostridium difficile* (*C. difficile*) outbreaks at Maidstone and Tunbridge Wells NHS Trust during 2005 to 2006. The report of this inspection was published in October 2007. This report included several recommendations to the trust including:

- **Action by the board**
  - Trust board's leadership to be reviewed

- **Clinical governance and the management of risk**
  - Control of infection to be an integral part of clinical governance
  - Control of infection to be given a higher priority across the trust
  - Appropriate reporting and investigation of serious untoward incidents
  - Analysis of the risks raised by incidents and complaints
  - A system that clearly demonstrates learning from incidents and complaints

- **Action by the board and managers to control the risk of infection**
  - Higher priority given by the trust board to the control of infection and factors that affect the ability of the staff to control infection
  - Ensure adequate information to monitor infections
  - Ensure effective isolation policy
  - Ensure infection control team functions effectively and operates an appropriate system for surveillance
  - Ensure good standards of hygiene

- **Staffing levels and training**
  - Additional nurse recruitment to ensure acceptable safe care

- **The Healthcare Commission also gave national recommendations that included**
  - Diagnosis of *C. difficile* should be counted as a diagnosis in its own right
  - This diagnosis must be taken seriously as it is potentially life threatening
  - Commissioners of care must ensure that acute trusts have appropriate guidelines for the prevention and management of this infection.
  - Antibiotic usage should be restricted to use of the narrowest spectrum antibiotics and for the shortest possible time.
  - Further consideration must be given to the education and supervision of trainee doctors.
  - There should be agreement between the NHS and the HPA about monitoring the rates of *C. difficile*.
  - The board of every NHS trust must understand the role and responsibilities of the Director for Infection Prevention and Control.

The elderly are biggest users of acute health care and are more likely to contract an HCAI. Action is required to minimise elderly patients picking up these infections. The most effective way of achieving this is to promote effective hand washing. There needs to be a campaign to remind staff, patients and visitors to wash their hands effectively.
Hepatitis

How are we addressing Hepatitis B and C in Kent?

The word “hepatitis” means inflammation of the liver. Toxins, certain drugs, some diseases, heavy alcohol use, bacterial and viral infections can all cause hepatitis. Some of these causes are associated with health inequalities, such as drugs and alcohol misuse. Hepatitis is also the name of a family of viral infections that affect the liver; the most common types are hepatitis A, hepatitis B, and hepatitis C.

Hepatitis B

Introduction

Hepatitis B is a blood borne viral infection that can be prevented through vaccination. The hepatitis B virus (HBV) causes hepatitis and can also cause long term liver damage.

In the UK, hepatitis B infection is usually acquired in adulthood, with sexual activity or injecting drug use being the most commonly reported routes of infection. Infection with the hepatitis B virus typically causes an acute infection, with a small number of those infected going on to develop chronic disease.

The World Health Organization (WHO) estimates that, in the UK, the prevalence of chronic hepatitis B infection is 0.3%. Hepatitis B is more common in other parts of the world such as south-east Asia, Africa, the Middle and Far East, and southern and eastern Europe. The WHO estimates that there are 350 million chronically infected people world-wide.
The virus may be transmitted by contact with infected blood or body fluids, such as through household or sexual contact with an infected person. The virus can be spread by the following routes:

- sharing or use of contaminated equipment during injecting drug use
- vertical transmission (mother to baby) from an infectious mother to her unborn child
- sexual transmission
- receipt of infectious blood (via transfusion) or infectious blood products (for example clotting factors)
- needlestick or other sharps injuries (in particular those sustained by hospital personnel)
- tattooing and body piercing

Some people may develop chronic hepatitis B infection. This is when they fail to clear the hepatitis B infection after six months and this leads to the chronic carrier state. Many people who become chronic carriers have no symptoms and are unaware that they are infected. Approximately 10% of these individuals remain infectious and will be at risk of developing cirrhosis and primary liver cancer.

Hepatitis B infection can be treated. Alpha interferon is an antiviral drug that is used to treat patients with chronic hepatitis B infection. Other drugs with antiviral properties, such as lamivudine, are also used. Not all patients are suitable for treatment. The response rate to treatment is variable and long-term therapy is often required.

Hepatitis B can be prevented. A vaccine is available to prevent the infection and should be given to all individuals who are at risk from hepatitis B infection in the UK. In some other countries, hepatitis B vaccine is routinely included in the immunisation schedule.

### Management of patients with acute hepatitis B infection

All patients diagnosed in Kent with acute hepatitis B infection should be notified to the Consultant in Communicable Disease (CCDC) at the Kent Health Protection Unit (KHPU).

1. **Identifying the source:**
   Staff in the Unit investigate and follow up all cases in order to establish where the patient may have acquired the infection. Part of the investigation involves an interview with the patient, either face-to-face or by telephone.

2. **Reducing the risk of onward transmission:**
   The information obtained is then reviewed and the possible source identified. If there are public health implications, these are addressed. The sexual, household and other close contacts of the case are offered hepatitis B vaccination, to prevent and control the spread of the infection.

3. **Referral for treatment and follow up:**
   The on-going treatment and monitoring of the case is then managed by the patient’s general practitioner and a gastroenterologist or hepatologist (liver specialist).

### Management of a pregnant woman who is diagnosed as a hepatitis B carrier

All pregnant women in Kent are offered screening for hepatitis B. Laboratories across Kent notify the KHPU of any pregnant chronic carriers. On receiving a laboratory report, the Unit follows a set protocol to ensure that when the pregnant woman delivers, her baby receives hepatitis B immunisation as per the recommended schedule. It is the responsibility of the patient’s GP and the designated Health Visitor, to ensure that the baby completes the course of vaccination.
Hepatitis B Notifications

Figure 24 Hepatitis Notifications in England and Wales 2007* by Age Group

Figure 1 shows the distribution of notifications across age groups for hepatitis B in England and Wales in 2007. The proportion of notifications amongst those aged under 15 is less than 2% of the total notifications for hepatitis B. There are a significant number of notifications amongst teenagers and young adults aged 15-24, with around 1 in 5 notifications in this age group. By far the highest number of notifications is in those aged 25-44, with 60% of the notifications occurring in this group. 16% of notifications in 2007 were in those aged 45-64, with a lower number in those aged 65 and over.

Hepatitis B Cases Reported to Kent Health Protection Unit

Table 8 Hepatitis B Cases in Kent by Sex 2007

<table>
<thead>
<tr>
<th>Sex</th>
<th>Acute</th>
<th>Chronic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>3</td>
<td>53</td>
<td>56</td>
</tr>
<tr>
<td>Male</td>
<td>9</td>
<td>26</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>81</td>
<td>93</td>
</tr>
</tbody>
</table>

* Includes 2 cases where sex is unknown.
Source: KHPU, Enhanced Hepatitis B Database.

Table 9 Hepatitis B Cases in Kent by Age Group 2007

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;24</td>
<td>16</td>
</tr>
<tr>
<td>25-34</td>
<td>42</td>
</tr>
<tr>
<td>35-44</td>
<td>17</td>
</tr>
<tr>
<td>45-54</td>
<td>10</td>
</tr>
<tr>
<td>55+</td>
<td>7</td>
</tr>
<tr>
<td>Total*</td>
<td>93</td>
</tr>
</tbody>
</table>

* Includes 1 case where age group is unknown.
Source: KHPU, Enhanced Hepatitis B Database.
Tables 8 and 9 above show the distribution across age groups and sex of cases of hepatitis B reported to the KHPU in 2007. The number of cases known to the KHPU is not the same as the number of notifications, this will be considerably higher, because the database will include chronic infections identified by laboratories, which are not usually notified.

There were a total of 93 cases reported to the KHPU in 2007, 12 of which were acute and 81 of which were chronic. Three quarters of the acute cases were male. Two thirds of the chronic cases were female (53 cases) and almost two-thirds of these were pregnant women, which reflects the fact that pregnant women in Kent are offered screening.

The distribution of cases known to the KHPU by age group broadly reflects the national distribution of notifications. Around 1 in 5 cases are aged under 24 and the highest proportion of cases is in those aged 25-34, at just over 60%. Again, it should be noted that screening activities influence the age distribution.

**Hepatitis C**

Hepatitis C is currently the most important infectious disease affecting those who inject drugs. Very high prevalences have been reported among injecting drug users in many countries. Up to 80% of those acquiring hepatitis C develop chronic infection and are at risk of developing cirrhosis and liver cancer. The development of more effective antiviral therapies means that the uptake of diagnostic testing for hepatitis C by current and former injecting drug users is increasingly important (HPA 2007).

The updated document, “Management of Hepatitis C in Kent and Medway: guidelines and local services”, was completed in July 2007 by a working group. It provides guidance on Hepatitis C services including identification, management and prevention.

The management guideline has been updated in line with both Department of Health and NICE treatment recommendations and formalises Kent and Medway PCT support for the delivery of Hepatitis C care.

Completion of the guideline has enabled the working group to begin addressing further aspects of Hepatitis C service provision by:

- Supporting all Kent and Medway microbiology laboratories to achieve locally agreed standards of testing.
- Initiating a review of the effectiveness of testing services across Kent and Medway, following the 2006 Director of Public Health Annual Report which recommended improving access to screening and testing.
- Initiating a baseline assessment of services across Kent and Medway to support future service review. Analysing where improvement is needed in PCT services.


The APPHG audit is intended to show how successful PCTs are, in achieving recommendations of the Department of Health Action Plan for England (2004).

Results published in 2008 showed improvement across all PCT areas: each area achieved a score of eight out of a maximum ten.
Housing, Housing-Related Support and the Kent Supporting People Programme

Background

Stable housing is fundamental to achieving good health and well-being. It is pivotal to quality of life, providing greater stability to deal with other issues, and decreasing social exclusion, through enabling vulnerable people to make links with their local communities and acquire social support networks.

The Supporting People programme delivers housing-related support to vulnerable people in order to help them to:

- maintain their current housing
- live more independently within their own communities
- prevent problems that can often lead a person being hospitalised, homeless, or placed into institutional care
- help with the transition to independent living for anyone leaving an institutional environment

Supporting People is a partnership including local authorities, Adult Social Services, the NHS and Probation. Kent County Council administers a budget of £32m on behalf of the partnership, which funds the delivery of housing-related support services. Such services are either delivered as floating (temporary) support in people’s own homes, wherever they live, or as accommodation-based services where support is available at particular buildings and often provided by staff located on the premises.
Housing-Related Support Services

Vulnerable people may need housing-related support for a variety of reasons, such as mental health problems, learning or physical disabilities, past homelessness, previous imprisonment or risk of offending, risk of domestic abuse, or they may be teenage parents, have problems with substance misuse, may live with HIV/AIDS, may be travellers or gypsies, may have difficulty in coping due to age or belong to an ethnic minority group.

Housing-related support is defined as “support services which are provided to any person for the purpose of developing that person’s capacity to live independently in the community or sustaining his / her capacity to do so” (Supporting People 2003). Support may include help with:

- life and social skills
- managing debts, budgeting and applying for benefits
- setting up home and resettlement support
- understanding tenancy agreements
- staying safe at home
- getting on with neighbours
- taking up day-time activities, training, education or employment
- dealing with other agencies such as health and advice services.

The Strategic Objectives of the Supporting People Programme

Services are planned to meet the strategic objectives and targets of the partnership (Kent County Council 2007), which include the promotion of services that meet local need and deliver quality of life, promote independence and contribute to meeting the crosscutting key objectives of Supporting People, which are to:

- prevent homelessness and repeat homelessness
- prevent unnecessary hospital admissions
- prevent unnecessary or premature admission to residential care
- prevent criminal or anti-social behaviour
- prevent people misusing substances, or re-using after treatment
- contribute to social inclusion and community cohesion

Housing-related support services provided under the Supporting People programme contribute to Public Health targets as follows:

- Reduce health inequalities in deprived areas through helping vulnerable people gain access to primary health care
- Reduce substance misuse and excessive alcohol drinking through helping vulnerable people to maintain a supported base from which drug and/or alcohol users can be supported by specialist intervention programmes
- Help people with mental health problems to maintain a supported base from which they can gain access to specialist treatment
- Improve children’s mental health and well-being through supporting vulnerable families to maintain stable housing
- Reduce youth crime and re-offending rates
- Help vulnerable and socially excluded people make links to their local communities and live more independently, by accessing training, education and employment

The Supporting People programme is fully integrated into the Local Area Agreement and contributes to many of its targets. The programme has its own specific target concerning the number of vulnerable people achieving independent living. The aim is that 70% of Supporting People clients in short-term supported accommodation should move into independence over the next three years, from a baseline of 65.7%.

A needs analysis published by the programme in November 2007 identified the following gaps in services, some of which have now been commissioned:

- More supported housing for young single homeless people, particularly in Dover, Dartford, Gravesesham, Sevenoaks, Shepway, Thanet and Tunbridge Wells.
- Short-term supported accommodation for teenage parents in Maidstone.
- An accommodation-based service for people misusing alcohol in west Kent.
- More short-term and long-term supported accommodation for people with mental health problems, especially in Ashford, Tonbridge and Malling and Dover.
- More specialist floating support services for people with mental health problems in east Kent.
• A service for people with dual diagnosis of mental health and drug or alcohol problems.
• More accommodation-based provision for people fleeing domestic abuse in the areas of Sevenoaks, Tonbridge and Malling, and Tunbridge Wells
• Handy person services to cover the whole of Kent
• Predicted need of supported housing for people with learning disabilities currently living with aged carers, which needs quantifying.
• Predicted need for additional extra-care accommodation for frail elderly people
• An outreach and resettlement service to support homeless people or those at risk of homelessness.

Recommendations

• Improve information sharing between the partner agencies to ensure that needs are identified and the right housing-related support is commissioned.
• Monitor the links between housing, health and social care in order to reduce inequalities and ensure that services are commissioned that enable vulnerable individuals to live in their own homes.

Housing-Related Needs of Ethnic Minority Communities

The housing-related support needs of all ethnic minority groups are reviewed periodically to ensure that the Kent Supporting People programme meets the diverse needs of all and enables fair and equal access to services.

In 2007 Supporting People investigated the housing-related needs of these groups as part of research (Kent County Council 2007a) into a range of hard-to-reach groups including asylum seekers, gypsies and travellers. The results included the following:

• Vulnerable members of South Asian communities in north Kent are meeting cultural barriers to accessing services. A specialist floating support service could meet their needs.
• Gypsies and travellers need a small specialist floating support service sensitive to this group’s distinct culture, with an emphasis on social integration.
• There may be a need in future for a specialist service for asylum seekers given leave to remain. At present, the numbers do not warrant this.
• There may be a need in future of specialist provision for Asian women fleeing domestic abuse.

This research led to the setting up of services for the South Asian groups in north Kent and for gypsies and travellers.
Carers’ health - a public health issue

At any one time 1 in 10 people in Kent is a carer. Throughout our lives most of us will either give or receive care. Many people do not class themselves as carers: they are mums and dads, husbands, wives, partners, brothers, sisters, friends and neighbours. People from all walks of life, ages and backgrounds are carers. Carers are not a separate or distinct group; caring touches all our lives.

Kent County Council’s agreed definition of a carer is:

A carer is someone who looks after family, partner or friend in need of help because they are ill, frail or have a disability. The care they provide is unpaid.

Carers provide the majority of community care and the costs of the care they provide, which includes personal and emotional support, treatment and 24-hour supervision, could never be replaced by health and community care services.

Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own (Department of Health 2008) is the new national carers’ strategy. It contains a specific and clear vision regarding carers’ health, which is that “carers will be supported to stay mentally and physically well and be treated with dignity.”

According to the 2001 Census, there are 127,848 carers in Kent. This equates to almost 10% of the population undertaking a caring role at some point during the week. Projections show that Kent’s population is ageing rapidly, with more people living longer with disability and illness. The focus of current health and social care policy is to support people to live in their own homes for as long as possible and provide more care and treatment closer to home. This will inevitably mean more care being provided in the community and much of this care is likely to be provided by carers. Services need to be able to respond to these trends and;

- recognise carers,
- treat them as expert partners in care, and
- support them to lead normal lives
This table contains information gained from the 2001 census, and shows that many carers are in fact providing what constitutes full time care.

<table>
<thead>
<tr>
<th>Care hours per week</th>
<th>Carers in Kent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 19 hours</td>
<td>90,752</td>
</tr>
<tr>
<td>20 - 49 hours</td>
<td>11,893</td>
</tr>
<tr>
<td>50 on more</td>
<td>25,203</td>
</tr>
<tr>
<td>Total</td>
<td>127,848</td>
</tr>
</tbody>
</table>

25,203 of Kent’s carers provide more than 50 hours of care per week. Although caring has historically been viewed as a predominantly female role, table 1 shows that in later life, more men aged 75 and over are carers than women. A Carers UK Study in 2004 showed that nearly 21 per cent of carers providing more than 50 hours of care report that they are not in good health, compared with only 11 per cent of the non-carer population. People who provide long hours of care are twice as likely to be in poor health themselves, and need to be supported both in their own right and in their role as carers.

Figure 25 Kent residents caring, by age and sex

Carers often ignore their personal health concerns and needs because their caring role does not allow the time to address them. Health and social care professionals have to be able to recognise that caring can place physical and mental stress on the carer.

Carers require advice, information and support to ensure that caring does not adversely affect their health. The services and support available to carers must be such that they are able to stay mentally and physically well throughout their caring role. Short breaks and respite care are key elements of carers support, as is the peace of mind of emergency or contingency plans.
The table above shows that the more hours of care a carer provides, the more likely they are to be in poor health themselves. It also evidences that older carers are more likely to experience poor health, with 34.1% of the over-85’s, providing more than 50 hours of care, whilst being not in good health.

The 2004 Carers UK survey also found that carers were more likely to report high levels of psychological distress, including anxiety, depression, loss of confidence and self-esteem, than non-carers. Stress experienced can be the result of being on call for long periods of the day and seeing no end to the caring role, and may lead to the deterioration of relationships. Stress may mean that carers neglect their own health, for example by not eating properly, or they may neglect, or even mistreat the person they are caring for.

Ensuring that carers are supported and prepared mentally and physically for their role is essential. Alongside the new national carers’ strategy the government announced that additional funding would be made available to establish ‘Caring with Confidence’ training programmes for carers. Based on the ‘Expert Patient Programme’ this training recognises that the caring role is often taken on suddenly and without preparation, leaving carers struggling with the new responsibilities they have assumed. The training is designed to empower and enable carers in their caring role, help to develop their advocacy skills and increase their ability to network with other carers to support their needs.

Caring and Paid Work

Care and caring are at the heart of the issues facing an ageing population, with more very aged people needing care and people having longer working lives. More people will need to juggle the dual responsibilities of work and caring. Of the 127,848 carers in Kent, 78% or almost 100,000 are of working age. Some will have given up work to care but the majority will be somehow combining caring with paid work. According to the 2001 Census there are 2564 men and 1394 women working full time whilst caring for more than 50 hours per week. In 2006 Carers UK found that working carers pay a heavy penalty in terms of their own health. Those with heavy caring responsibilities are two to three times more likely than workers without caring responsibilities to be in poor health.
The combination of an ageing population and declining working population, means that the role carers play in the workforce will be of increasing importance; carers will have to combine caring with paid work. Therefore it is of vital important that employers support employees with caring responsibilities and provide measures to support carers in the work place, using initiatives such as flexible working or condensed hours. The Work and Families Act 2006 extended the right to request flexible working to employees who care for an adult.
The Importance of Health Services

Primary Care is very often a carer’s first point of contact with services and therefore should play a key role in supporting carers, signposting them to appropriate services. The support and understanding of carers’ needs by GP is variable. The new national carers’ strategy recognises the importance of primary care and announces a range of NHS focused carers’ pilots:

- looking at how the NHS can better support carers in their caring role through developing models of best practice and enabling more joined-up service provision between the NHS, local authorities and the third sector
- improving the support offered by GPs for carers, and
- piloting of annual health checks for carers.

Annual carers’ health checks will provide an excellent means of providing carers and health professionals with an opportunity to work in a preventative way to identify and deal with any emerging health problems the carer may have. This will enable them to care whilst remaining in good health. It is highly cost effective for the NHS to support carers who can support early discharge and prevent unnecessary readmission to hospitals. Carers also provide long-term care, often involving nursing tasks, frequently without any support from either the NHS, social services, other members of their family or the local community.

For the first time, in 2008/2009, the Operating Framework for the NHS makes specific references to supporting carers. It sets out an expectation that Primary Care Trusts should aim to create a more personalised service that provides support for carers, and which recognises their need for breaks from caring. This sends a clear message to health professionals that providing carers’ support is part of the work of the NHS. To further this, the new carers’ strategy announced that £150m over two years will be allocated to PCTs, who will be required to work with their local authority partners to publish joint plans, as part of the joint strategic needs assessment process for the provision of service for carers and especially short/emergency breaks.

Table 11  Female carers in KENT by employment status and weekly hours of care

<table>
<thead>
<tr>
<th>Female carers aged 16-59</th>
<th>Caring 1-19 hours</th>
<th>Caring 20-49 hours</th>
<th>Caring 50+ hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of working age</td>
<td>38,528</td>
<td>5,339</td>
<td>9,625</td>
</tr>
<tr>
<td>In full-time work</td>
<td>13,937</td>
<td>1,408</td>
<td>1,394</td>
</tr>
<tr>
<td>In part-time work</td>
<td>13,527</td>
<td>1,468</td>
<td>2,008</td>
</tr>
<tr>
<td>Unemployed</td>
<td>862</td>
<td>128</td>
<td>167</td>
</tr>
<tr>
<td>Permanently sick or disabled</td>
<td>1,042</td>
<td>323</td>
<td>847</td>
</tr>
<tr>
<td>Looking after home/family FT</td>
<td>6,094</td>
<td>1,552</td>
<td>4,544</td>
</tr>
<tr>
<td>(Early) retired</td>
<td>1,216</td>
<td>140</td>
<td>229</td>
</tr>
</tbody>
</table>

Source: 2001 Census Standard Tables, Crown Copyright 2003
Kent Carers’ Priorities

Kent Adult Social Services recently undertook research, which identified five key priorities for the development of carers’ support services in 2008/09, all of which are consistent with the National Carers Strategy priorities. In brief they are:

- **A Single Point of Contact** - a county-wide dedicated advice and information helpline service for carers
- **Carers’ Emergency Card** - 24/7 contact number in case of an emergency. This means that if a carer becomes ill or is involved in an accident they can be assured that there will be someone to look after the person that they care for.
- **Carers’ Training and Education** - to cover topics such as moving and handling, medication, dealing with difficult or challenging behaviour, coping with specific conditions and employment - all of which could be linked to the Carers with Confidence Programme.
- **Carers’ Emergency Support Services** - developing time-limited (48-72 hours) home-based emergency cover to provide support in times of crisis e.g. carer’s unplanned admission to hospital or a medical emergency, a family member being taken ill and requiring help or attention, the death or funeral of a close friend or family member.
- **Short breaks** - Increasing the type and availability of short breaks, including at home, in the evening and overnight.

**Recommendations:**

- Services should be developed to deliver the five joint priority areas mentioned above
- Development of a multi-agency Kent adult carers’ strategy and action plan
- A health and social care joint commissioning strategy for carers’ services
- Carers to be recognised as an ‘at risk’ group who experience significant health inequalities
- Primary care to take an active role in health promotion for carers, including annual health checks and flu vaccination
- Better support for carers in paid employment.
Dental Health

Inequalities in Oral Health - Bridging the gap

Although in Kent we have some of the best levels of oral health in England as measured by national surveys, there are still variations across the county. The data we have for adults is scant but local surveys in children do highlight these inequalities. The proportion of children having suffered no dental decay at all is high but within these figures there are differences seen from one local authority to another (Table 12).

Table 12 Caries experience in 5 year-old children across Kent and Medway

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Decayed teeth (d)</th>
<th>Missing teeth (m)</th>
<th>Filled teeth (f)</th>
<th>dmft</th>
<th>dmf teeth %</th>
<th>Dmf &gt;0</th>
<th>Caries free %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashford</td>
<td>0.54</td>
<td>0.11</td>
<td>0.04</td>
<td>0.69</td>
<td>18.44</td>
<td>3.11</td>
<td>81.56</td>
</tr>
<tr>
<td>Canterbury</td>
<td>0.51</td>
<td>0.09</td>
<td>0.11</td>
<td>0.70</td>
<td>18.37</td>
<td>3.11</td>
<td>81.66</td>
</tr>
<tr>
<td>Dover</td>
<td>0.59</td>
<td>0.06</td>
<td>0.07</td>
<td>0.72</td>
<td>24.10</td>
<td>2.99</td>
<td>75.90</td>
</tr>
<tr>
<td>Shepway</td>
<td>0.59</td>
<td>0.15</td>
<td>0.16</td>
<td>0.89</td>
<td>25.67</td>
<td>3.47</td>
<td>74.33</td>
</tr>
<tr>
<td>Swale</td>
<td>0.33</td>
<td>0.02</td>
<td>0.06</td>
<td>0.41</td>
<td>15.92</td>
<td>2.70</td>
<td>84.08</td>
</tr>
<tr>
<td>Thanet</td>
<td>0.56</td>
<td>0.11</td>
<td>0.10</td>
<td>0.76</td>
<td>23.56</td>
<td>3.24</td>
<td>81.56</td>
</tr>
<tr>
<td>Dartford</td>
<td>0.29</td>
<td>0.02</td>
<td>0.70</td>
<td>0.39</td>
<td>14.18</td>
<td>2.73</td>
<td>85.82</td>
</tr>
<tr>
<td>Gravesend</td>
<td>0.28</td>
<td>0.11</td>
<td>0.11</td>
<td>0.49</td>
<td>18.44</td>
<td>2.68</td>
<td>81.56</td>
</tr>
<tr>
<td>Maidstone</td>
<td>0.15</td>
<td>0.04</td>
<td>0.08</td>
<td>0.28</td>
<td>14.24</td>
<td>1.93</td>
<td>85.76</td>
</tr>
<tr>
<td>Sevenoaks</td>
<td>0.15</td>
<td>0.01</td>
<td>0.12</td>
<td>0.28</td>
<td>11.21</td>
<td>2.54</td>
<td>88.79</td>
</tr>
<tr>
<td>Tonbridge</td>
<td>0.31</td>
<td>0.02</td>
<td>0.11</td>
<td>0.44</td>
<td>15.31</td>
<td>2.90</td>
<td>84.69</td>
</tr>
<tr>
<td>T. Wells</td>
<td>0.17</td>
<td>0.02</td>
<td>0.6</td>
<td>0.25</td>
<td>10.64</td>
<td>2.37</td>
<td>89.36</td>
</tr>
<tr>
<td>Medway</td>
<td>0.34</td>
<td>0.02</td>
<td>0.12</td>
<td>0.49</td>
<td>17.02</td>
<td>2.86</td>
<td>82.98</td>
</tr>
</tbody>
</table>

Data from local epidemiological surveys 2008
In a recent survey of 5-year-old children where we measured the number of decayed, missing and filled teeth (dmft) in a representative sample there was over a three and a half fold difference between children in the local authority having the most caries experience and the least (Figure 28). In Shepway on average a child would have 0.98 diseased teeth whereas in Tunbridge Wells this figure is only 0.25 teeth.

**Figure 28 Decayed, filled and missing teeth in children aged 5**

[Graph showing dmft values for different areas]

The averages shown for caries in the 5-year-old population are however a little misleading as so many children have no disease at all. If we look at the figures for those children who have had dental caries then the picture is not so good. The data show that in the worst area a child with decay is likely to have 3.47 decayed teeth as compared to 1.93 decayed teeth in the best area (Figure 29).

**Figure 29 Decayed, filled and missing teeth in 5 year-old children (for those with decay experience)**

[Graph showing dmft values for different areas]

These patterns of inequalities seen in children are more than likely to be mirrored in the adult population and it is important to ensure good dental services are available to the population particularly in these areas of need.

Access to an NHS dentist has been a major issue for many people both locally and nationally and as a result there have been concerns over oral health that has prompted the government to act (Figure 30). In 2006 they introduced a new contract that they said was fair for dentists and more understandable for the public. The immediate consequence of this was many dentists refusing to work under the new contract arrangements and so initially making the situation of worse.
In the past the old contract arrangements led to a typical inverse care situation where dentists sited services in areas where there may have been less need in the population. Oral health is associated with areas of deprivation, the more deprived areas having the poorest oral health. Inequalities in health were matched with inequalities in dental services.

This changed with the new contract and for local health organisations it was a blessing and a curse. For the first time Primary Care Trusts held the budget for General Dental Services and were able to contract directly with dentists in areas where they felt there was a need for NHS dentistry, rather than dentists themselves deciding where they would like to open a surgery. However, the immediate reduction in services following the introduction of the contract gave PCTs a new problem, as they were now responsible for the delivery of a comprehensive dental service with fewer dentists willing to work for the NHS.

Indeed during the first year, following the introduction of the new contract, the number of people seeing a dentist in a 24-month period fell across West Kent and Eastern and Coastal Kent by about 2% (Figure 31). A small reduction but this represented approximately 21,700 fewer people attending a dentist. Interestingly access did not reduce uniformly across the PCTs as the higher socio-economic areas lost more NHS dentists. For example, in West Kent the northern areas of Dartford and Gravesend had some loss of dentists but the main reduction in service was in the South West of the patch where it was already difficult for some people to access NHS treatment.

In the last year the PCTs have been working hard to increase access to NHS dentistry by initially issuing temporary contracts to existing dentists who were willing to increase their patient base and by a tendering process for new practices in areas of low provision and high dental need. So far West Kent have commissioned new practices in Gravesend, Larkfield, Sevenoaks, Tonbridge, Tunbridge Wells and Staplehurst. This has been an investment of nearly £2 million with an increase in activity of 14%. In Eastern and Coastal Kent temporary contracts are in place but plans are advanced for new surgeries in Dover, Broadstairs, Canterbury, Margate, Eastchurch, Folkestone, Ashford, Sittingbourne, Whitstable and Deal with an investment of nearly £2.5 million, increasing services by 13%.

With the changes outlined we would hope to see improvement in the availability to NHS care across the PCTs next year. It often appears to be an accepted fact that NHS dental treatment is not available when the public are asked about their dental attendance. In some places this is not so and with the new investments in dentistry it is important to ensure people know how to access their dental services. In more deprived areas where a smaller proportion of people tend to visit the dentist regularly we will be looking at ways to increase attendance now that services are available.

The government have ring-fenced the dental budget until 2011 so with continuing evaluation of service uptake we will be planning further improvements to the General Dental Service to reduce inequalities in care that may at present exist.
Maternity Matters in Kent

Introduction

The government’s ‘Maternity Matters’ policy (2007) promotes excellence in maternity care through a commitment to offer all women and their partners a wider choice.

It builds on the vision of a modernised, woman-focused and family centred maternity service as described in the Maternity Standard of the National Service Framework (NSF) for Children, Young People and Maternity Services (2004). The NSF acknowledged the importance of addressing the needs of women and their partners before the woman becomes pregnant, throughout pregnancy, during childbirth and beyond, as they embark on parenthood and family life. This is because a mother who has received high quality maternity care throughout her pregnancy is more likely to have a healthy baby and is well placed to provide the best possible start in life for her baby.

Maternity Matters describes four national choice guarantees that are to be available for all women and their partners by the end of 2009. These cover:

1. how to access maternity care;
2. type of ante-natal care;
3. place of birth;
   and
4. post-natal care.

Services should be designed to overcome barriers to access and to reduce inequality.
Health Inequalities and Maternity services

A Joint Strategic Needs Assessment (JSNA) has been completed for Kent. This document identified a number of health inequalities within the County.

There was inequality in:
• the way services were accessed
• Health outcomes before, during and after pregnancy
• Health outcomes of the mother

Eastern and Coastal Kent PCT (ECKPCT) has an infant mortality rate (IMR) that is consistently higher than West Kent PCT (WKpCT), though still below the England average. This is likely to be a reflection of the higher levels of deprivation in ECKPCT. Early access to effective maternity services may play a role in reducing this rate.

Figure 32 Infant mortality rate trend 1998-2006

In West Kent PCT (WKpCT) in particular, there is a trend towards increasing age of the mother. The national trend of an increasing number of births to foreign-born women is also valid for Kent, although not to the same extent. In 2006 13% of the births in Kent were to women who were born abroad, more than double the 6% in 1996 but still much less than the national average of 21.9%.

Figure 33 Proportion of maternal births by age band, Districts in West Kent PCT
There is great variability in provision of pain relief between maternity units and an apparent lack of options, including birthing pools, at the hospital units in EKHT.

**Teenage mothers** - The main issues for teenage mothers are encouraging early access to services, reducing smoking and encouraging breastfeeding.

**Women in Black or Minority Ethnic (BME) groups** - The key issues for women will vary between each ethnic group and between the PCTs. The most important thing for this group is encouraging early access to services and maintaining that relationship.

**Women in deprived areas** - For women in deprived areas, the main issues are addressing their clinical risk factors and providing support for behaviour change, such as smoking cessation, both ante- and post-natally.
Women in the most deprived 40% of wards in Kent and Medway were highly statistically significantly (p<0.001) more likely to be teenage mothers, to be smoking at booking and birth, to have substance abuse (but not alcohol) problems, to have a BMI of over 30 and to be in a BME group.

Table 13 Prevalence of risk factors in women in the most deprived areas in Kent?

<table>
<thead>
<tr>
<th>Deprivation quintile 1/2</th>
<th>&lt;18</th>
<th>&gt;40</th>
<th>Smoker at booking</th>
<th>Smoker at Birth</th>
<th>Alcohol consumption (often)</th>
<th>Drug Abuse</th>
<th>BMI &gt; 30</th>
<th>BME groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>All women</td>
<td>2.22%</td>
<td>3.32%</td>
<td>21.51%</td>
<td>18.52%</td>
<td>0.86%</td>
<td>1.05%</td>
<td>14.14%</td>
<td>13.83%</td>
</tr>
</tbody>
</table>

What is being done

Work has already begun on consulting women to establish their opinions on how they would like to see maternity services provided. Having explicitly described these it should follow that:

- potential service models are developed and appraised;
- options for service provision are determined;
- pathways of care are analysed and agreed;
- service planning and commissioning planning follow, with agreements to be reached on appropriate service design for implementation by the end of 2009;
- there is continued patient and public involvement in all these processes;
- once plans are finalised an equality impact assessment must be performed;
- a dataset for monitoring maternity services is agreed and follow up data monitoring established with identified clinical and public health expertise support.

Further work needed

Further specific work in relation to the needs of the following groups is needed: women with disabilities; diabetes in pregnancy; obesity in pregnancy, other complications in pregnancy; perinatal mental health services; and pre-conception care.

Key recommendations to reduce health inequalities

- Women from vulnerable groups should be consulted to ensure that services meet the needs of these populations and are provided in such a way as to reduce barriers to access and promote ongoing contact with services.
- Pregnancy and childbirth are identified as ideal opportunities to engage those parents who may not normally contact services and who are likely to be particularly receptive at this time. Integration of maternity services into community settings, such as Sure Start Centres, is advocated by ‘Maternity Matters’ to engage vulnerable families and improve uptake of available services.
- Further work on the feasibility of midwives being incorporated into Sure Start Centres in Kent is needed.
- For all vulnerable groups the key issues are addressing risk factors, many of which are behavioural, and improving access to services. These are all difficult issues and extensive consultation with each group in different localities will be required in order to determine how best to proceed.

Life chances are determined in the early years and indeed, even in the gestation period. Smoking and heavy drinking during pregnancy can lead to low-birth weight babies and a greater risk of infant mortality. Low-birth weight babies are more likely to develop behavioural problems and be poor achievers in school, as well as being more susceptible to further health problems. We will do more to improve access to maternity care among vulnerable young women and ensure early identification of pregnant women and children who are at risk from health problems. (Alan Johnson speech on Inequalities 9/6/08)
Health and the Environment

Inequalities and extreme weather

Heatwaves and cold snaps tend to target the more vulnerable in society. Flooding is more random and relates particularly to housing policy and isolation as to whom it affects.

Extreme weather and its impact on the health of the Kent population

Climate change or global warming has been debated for a number of years now, with the possible source of the changing temperature regularly featuring in the news. As a result scientists are trying to predict the future impact of any temperature changes. This chapter will not attempt to investigate the source of global warming or make long-term predictions. What we aim to do is to discuss the recent history of severe weather throughout the country and look to see how such events could affect Kent if they were to happen here.

It is worth noting the importance of the recent Civil Contingencies Act (2004). This Act places six requirements on all public bodies, referred to as category 1 organisations (there is one additional requirement placed on local authorities). Category 1 organisations comprise all NHS organisations, all local authorities and the ‘blue light services’. These organisations form, within Kent and Medway, the Kent Resilience Forum. For more information on the Civil Contingencies Act, Category 1 organisations and local resilience forums please visit [www.ukresilience.gov.uk](http://www.ukresilience.gov.uk).
Recent examples of extreme weather

FLOODING
During the summer of 2007, large parts of the country experienced heavy rainfall, which led to severe flooding in Yorkshire, Humberside, Gloucestershire and parts of South Wales. The three months between May and July were three of the wettest months on record and as a result of the events that followed, 48,000 homes and 7,000 businesses were damaged, and 13 people died (Cabinet Office 2008). Power and water supplies were lost, railway lines, eight motorways and many other roads were closed and large parts of five counties and four cities were brought to a standstill. The situation could have been even worse had the Ulley reservoir and the Walhem switching station been reached by the flood waters.

The effect on local communities was enormous, health and social care organisations were greatly disrupted and the capabilities of responding agencies were stretched almost to breaking point.

HEATWAVE
During the summer of 2003, Europe was gripped by a long-lasting heatwave, with temperatures reaching over 40°C in France. In France alone nearly 15,000 people died as a direct result of the heatwave, which is also believed to have resulted in the death of 2,000 people in the UK (BBC news). These deaths occurred over a short period and mainly affected the elderly population. The problem was exacerbated by the fact that the heatwave peaked during the French national holidays, when many medical personnel and civil servants were on vacation, leading to a slower than normal response and contributing to the large number of deaths.

Effects of such an incident on Kent
An event of this size could cause huge problems for Kent, as demonstrated by the Yalding flooding in 2000. There are several sites of critical national infrastructure in Kent, similar to the Walhem switching station, and if these were affected in a similar or even more disruptive way, the result could be a very large major incident for the whole of Kent. This would affect all the emergency services and local authorities.

Due to the isolated nature of some of the communities in Kent, it would be particularly challenging for multi-agency organisations to respond effectively.

The after-effects of an incident of this scale would be a huge challenge for local authorities and the health service, in ensuring that the recovery of the community happened as swiftly and as efficiently as possible.

Effects of such an incident on Kent

To plan for such an event, the Department of Health has published a new national heatwave emergency plan (2008). This plan has been adopted by all NHS organisations within Kent.

Historically the effects of winter and cold weather have caused the greatest pressures on the NHS and social care. This emphasis is slowly changing and so planning is taking place to mitigate the effects of a possibly devastating heatwave in the future.

The Pitt Review
Following the 2007 floods across large parts of the country, Sir Michael Pitt, the former Chief Executive of Kent County Council, was asked by ministers to conduct a review into the flooding and identify any areas that required urgent action. This report was recently published, making 92 recommendations for national and local planners.
The report made 3 specific recommendations for healthcare professionals, as follows:

- the impact of flooding on the health and wellbeing of people should be monitored, and actions to mitigate and manage the effects should form part of the work of recovery coordinating groups;
- local response and recovery coordinating groups should ensure that health and wellbeing support is readily available to those affected by flooding, based on advice developed by the Department of Health;
- the Department of Health and other relevant bodies should develop a single set of flood related health advice for householders and businesses, which should be used by all organisations nationally and locally, and made available through a wide range of sources.

All organisations identified under the Civil Contingencies Act are working closely to implement these recommendations and to ensure that the lessons from the recent flooding are taken on board.

The Kent Resilience Forum has established a working group to specifically examine the Pitt Review recommendations and to ensure that as far as possible they are implemented within Kent.

One of the recommendations made by the Pitt review team was that individuals should make up a flood kit, including personal documents, insurance policies, emergency contact numbers, torch, battery or wind-up radio, mobile phone, rubber gloves, wet wipes or antibacterial hand gel, first aid kit and blankets. This flood kit would also be useful for other emergencies. This recommendation is fully supported by the emergency planning community in Kent, and all readers are advised to have such a kit prepared.

What the emergency planning community is doing to mitigate extreme weather

The Kent Resilience Forum is now working through its ‘Severe Weather’ sub-group to examine all forms of severe weather including flooding and heatwaves. As part of this work the group is developing flood plans, taking a Kent-wide approach, for the highest risk communities. The Resilience Forum is also working to ensure that all plans inter-link with each other, so that the community is supported as much as possible.

Along with planning a response to specific incidents, the Kent Resilience Forum is also working closely with the local media, in an attempt to improve warning and information policies and their implementation when an incident occurs.
Improving the quality of health services

Urgent Care

Definition
Urgent, unplanned or emergency care is for times when there is an accident or sudden illness when help is needed immediately.

Background
Trauma is the fourth leading cause of death in the UK and the leading cause of death in the first four decades of life. As the incidence of trauma is particularly high in the younger population; an average of 36 life years are lost for every trauma death (Chaira and Chimbanissi 2003). Over a third of these deaths are due to road trauma (Royal College of Surgeons of England/British Orthopaedic Society 2000). In addition, trauma is also a major cause of debilitating long-term injuries. For each trauma fatality, there are two survivors with serious or permanent disability (Trauma Audit and Research Network, see http://www.tarn.ac.uk).

By 2010, the Department of Health aims to have reduced the incidence of accidents by at least 20% from the baseline that was set in 1996.

The proportion of accidental deaths differs by age group. With the greatest proportion of deaths occurring in those aged 65 and over. [Figure 36]. Eastern Kent and Coastal PCT has higher rates of accidental deaths in all age groups [Figure 37]. West Kent has lower rates of deaths in those aged 65+ despite having a larger population in this age group.
The organisation of trauma services does have a direct impact on the outcome for the patient in critical cases and this has been measured using data from the Trauma Audit and Research Network (TARN) however only about half of acute hospitals report data to TARN (Trauma Audit and Research Network 2000).

A recent report from the Royal College of Surgeons of England (2006) showed that high quality trauma care is not consistently available within the NHS. This was noted by Lord Darzi, in the recent NHS Framework for Action (Healthcare for London 2008).
What is being done

In an emergency it is a high priority for all of us to obtain treatment quickly. Waiting times are getting much shorter but many people still go to hospital Accident and Emergency Departments (A&E) when they could get appropriate care elsewhere, for example at general practice, community pharmacist or by ringing NHS Direct.

Effective urgent care is achieved through a coordinated network of services to ensure that patients of all categories are treated in appropriate settings, and facilities required for the relatively small group requiring the highest level of specialist support are available when needed.

South East Coast SHA is a national pilot site for improving urgent care and work is planned including:

- Reducing hospital admissions for people with long-term conditions and providing intermediate care and rehabilitation services;
- Using a single assessment process;
- Improving care at the end of life;
- Developing new roles for ambulance staff, nurses and other professionals providing care in a range of settings. Ambulances are becoming more like mobile treatment centres, with specially trained staff. Ambulance staff also know the best place to take patients who need hospital care in order to avoid subsequent transfer.

Next Steps

Discussions will be held with interest groups about how to improve all aspects of urgent care.

Recommendations

- All acute hospitals giving treatment for urgent care should participate in the national Trauma Audit and Research Network (TARN) to measure local outcomes of patient care.
- The work of the national pilot should continue and report to Trust Boards and PCTs in Kent and Medway.
- To work with young people, focusing on prevention

Specialist Urology Services

Urology Improving Outcomes Guidance (IOG) report, which measured compliance with National Cancer Action Team guidance, published in 2002, led to review of commissioning specialist urology services. Detailed reviews have been undertaken since 2002, but these have failed to identify a pattern for multi-disciplinary team-working in NHS Trusts across Kent and Medway to provide sufficient critical mass of patients treated.

Although this applies to all highly specialised urological procedures, it is particularly relevant to compliance with IOG.

This review process has involved stakeholders on the Urology Commissioning Steering Group (UCSG), throughout. They agreed the process to be undertaken and the detailed content of the commissioning specification used in Stage 1. NHS Trusts were then asked to respond to this specification. An evaluation panel considered the responses and the results of the scoring of the various elements addressed. The Evaluation Panel membership included three respected surgeons external to the area as well as patients, PCT commissioning, public health, clinical and finance representation from within Kent and Medway. They concluded that:

- There is a need to ensure high standards of patient care, wherever they are treated
- Clinical teams need to be of a size which allows sub-specialisation and the ability to produce the highest outcomes
- Providers need to have vision and capacity to embrace new treatments and technologies
- Providers must be able to attract and retain a high calibre workforce.

The Evaluation Panel agreed that there should be two multi-disciplinary team arrangements, one in East Kent and one in West Kent. The external surgical members of the panel went further to state that in West Kent there should be one surgical site for highly specialised urology. It was indicated that further work (Stage 2) was required to identify the casemix, a feasibility study to identify which site, and impact on patient experience. The Kent and Canterbury Hospital will continue to be the surgical site in East Kent.
The Urology Commissioning Review has now reached Stage 2 of its process which will involve a selection process between two provider groups in West Kent with respect to the provision of the highly specialised elements of the Urological surgical service. This will represent just under 2% of the total operations performed in Urology. The two provider groups are a combined provider comprising of Darent Valley and Gravesend NHS Trust and the Medway Foundation Trust and a single provider – the Maidstone and Tunbridge Wells NHS Trust.

A decision on the location of the single surgical site for specialist urological cancer surgery is expected mid-year 2008.

**Vascular Services**

A review of vascular services was established to ensure the successful development of a vascular network within Kent and Medway, provided from two centres, one at Medway Maritime Hospital and the other at Canterbury hospital (East Kent Hospitals Trust). It was also intended that service standards should be developed, against which local services could be assessed.

A vascular steering group was established in September 2007. It was supported by a clinical sub-group, which endorsed the use of the Scottish clinical standards of care for vascular services, with some amendments. The centres also undertook baseline assessments against these standards. The sub-group agreed the minimum activity for abdominal aortic aneurysms and carotid endarterectomy. A vascular network has now been established in Kent and Medway. It will support the continuing improvement of vascular services and will also assist in the implementation of the national abdominal aortic aneurysm screening programme in Kent and Medway. The network will also help with the planning and development of vascular services in Kent and Medway.

**Stroke services**

As a nation we spend more than most on stroke, and a greater proportion of our health budget, but overall have worse outcomes. Stroke was highlighted as a specialist service requiring focused attention and West Kent PCT is leading the development work.

Better quality preventative care, emergency treatment and rehabilitation in the most appropriate setting, with expert staff, can actually save money. Many strokes can be prevented and the impact minimised if specialist treatment and care are reached quickly.

A service plan will be developed across Kent and Medway.

**Changes agreed**

A new care pathway has now been approved by all organisations across Kent and Medway including South East Coast Ambulance. The care pathway maps against the new national strategy and sets a very challenging development agenda for all organisations. Once implemented fully this will deliver lower mortality and improved outcomes for patients

- Two clinical rotas will operate, one for West Kent and Medway and another for East Kent to provide 24-hour thrombolysis services and 7-day transient ischaemic attack (TIA) services.
- A stroke network has now been established for Kent and Medway, and a Director appointed. This network, together with the former cardiac network, forms the new Cardiovascular Network for the whole of Kent and Medway, jointly funded by the three PCTs.

The SHA is supporting the implementation and monitoring of improvements in stroke services. The Sentinel audit will monitor performance in 2008, to ensure that significant improvements can be demonstrated from the 2006 results.

**Further Progress already made:**

- Allocation by the Department of Health of additional resources for local acute service improvements, and this will be used by PCTs to fund already identified acute projects as part of the development planning process.
- Social Services have been investing in stroke services through the Department of Health and discussions are underway to maximise impact of the investment.
- Two new consultants are being recruited for Darent Valley Hospital and Maidstone Hospital, along with additional consultant recruitment for East Kent Hospitals
• An acute stroke unit has been opened at the Kent and Sussex Hospital although a full range of services including full therapies are still being implemented.

• The new care pathway and TIA clinic access information has been shared with GP’s in West Kent and discussions have been held with four of the Practice Based Commissioning Groups around an approach to primary prevention.

• All community providers have reviewed their team structures and processes to meet the standards laid down in the development plan. Service revisions are being worked through and recruitment is underway.
Audit of the 2006 Annual Public Health Report

As part of the process for the production of the 2006 Kent Annual Public Health Report, there was an agreement that an audit of the report would be undertaken. The Faculty of Public Health Guidance on the production and content of annual reports includes an audit tool. The audit assesses seven key areas: Fitness for purpose, Consistency, Independence, Timeliness, Accountability, Promoting partnership, and Accessibility. 27 standards were used to audit the report.

93% of the standards were fulfilled. Two standards were unfulfilled. Firstly that the website does not currently use a structured query language that is tagged using the public health information tagging standard. Secondly, that a standard for the clarity of language was not defined in advance.

Recommendations for the Kent Annual Public Health Report are:

- To give clearer standards and guidance to authors
- Continue website development to include the public health information tagging standard
- Improve publicity and press coverage by greater collaboration with Communications teams
- Develop easier-to-read versions of the Kent APHR including a Children’s Version.
Health Inequality Indicators

LIFE EXPECTANCY

Kent residents in general can expect to live slightly longer than the national average of 77.3 years for males and 81.6 years for females. However even at local authority level there are differences of 4.3(males) and 3.5(females) years in life expectancy and these become starker (up to 17 years) when comparing electoral wards (Kent PCTs/County Council 2007).

There are strong correlations between deprivation, increased health risks (smoking, obesity, alcohol misuse, poor control of conditions such as hypertension, high cholesterol) and lower life expectancy.

To address these inequalities in life years, strategies aimed at the underlying risks need to have sharper focus where the potential health gain is greatest. To this end the Kent Public Health Observatory has been tasked to provide detailed data at the level of GP practices, super output areas and postcodes to identify where resources need targeting.

LIFESTYLE

The highest prevalence of smokers is found in Swale LA residents with 29.4% prevalence with the lowest in Sevenoaks LA at 19.8%.

A quarter of Kent residents smoke, but this is changing. The smoking ban of July 2007 and the continued development of the smoking cessation services within the PCTs have aided in the downward trend by a further two or three percentage points.

East Kent has the highest number of alcohol related admissions in the County. KCC have established a select committee to identify how best to deal with alcohol related problems. Additional resources are being developed in East Kent to treat alcohol misuse.

Binge drinking – 15.3% of Kent County residents binge drink, the highest prevalence is found in Swale LA with 16% with the lowest in Sevenoaks LA at 14.8%.

Obesity is a growing concern and increasing problem nationally. 23.4% of Kent residents are obese; this is higher than the national average. There are many initiatives tackling diet and exercise throughout the County.

<table>
<thead>
<tr>
<th>Area</th>
<th>Estimated Prevalence of Obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent County</td>
<td>23.4</td>
</tr>
<tr>
<td>Eastern &amp; Coastal Kent PCT</td>
<td>24.0</td>
</tr>
<tr>
<td>Swale LA</td>
<td>26.5</td>
</tr>
<tr>
<td>Sevenoaks LA</td>
<td>20.7</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics - Neighbourhood Statistics
The percentage of children who are overweight or obese, 2006/08

*percentage of those measured.
Source: National Child Measurement Program

A National scheme to aid in halting obesity in children commenced from the 6th of April 2007. This included monitoring the weight of Reception and Year 6 children.

Dartford and Swale local authorities have the lowest proportion with only 21% of adults consuming at least five portions of fruit or vegetables a day. Tunbridge Wells has the highest proportion with 34.6%.

**BIRTHS**

- England has a still birth rate of 5.35 whilst Kent County has a slightly lower rate at 5.07. Both PCTs have rates lower than those for England with 5.05 and 5.09 for WKPCT and ECKPCT respectively.
- England has a general fertility rate of 60.34 whilst Kent County has a rate per thousand female population aged 15-44 of 60.04. WKPCT has a higher general fertility rate at 61.46 whilst ECKPCT is lower at 58.7.
- The infant death rate for England is 5. Both PCTs have lower rates at 3.3 and 4.8 for WKPCT and ECKPCT respectively.

Less than a third (28%) of Kent County residents consume at least five portions of fruit or vegetables a day.
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Improving the Quality of Health Services

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Health Inequality Indicators

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