Working together for a healthier Kent

The first Annual Report for Kent of the Director of Public Health 2006 - Management summary
Introduction
Public Health in Kent 3
Why do we have a Public Health Report? 4

Demographics
Population 5
Life Expectancy 8
Deprivation 8

Health Status
Key Health Indicators 11
Mortality 12
Disease morbidity 13
Lifestyle behaviours 14
Progress towards Our Healthier Nation Mortality Targets 14
Health Inequalities 15
Partnership working 17

Children
Births 22
Infant Mortality 22
Low birthweight babies 23
Limiting Long-Term Illness 23
Children and Young People receiving care 23
Conception rates 25
Towards a Strategic Needs Assessment 26
Recommendations 26

Older People
Population change 27
Health of Older People 27
Recommendations 28

Smoking
Smoking and Deprivation 30
Hospital Admissions and associated costs 30
Tobacco Control and Stop Smoking services 31
Recommendations 31
The first Annual Report for Kent of the Director of Public Health - summary

**Obesity**

Obesity Management programmes 32
Recommendations 33

**Mental Health**

Size of the problem 34
Suicide Prevention 34
Recommendations 35

**Drugs and Alcohol**

Treatment in Kent 36
Trends for young people in drug and alcohol use in Kent 36
Gaps in service provisions 37
Recommendations 38

**Sexual Health**

GUM services 39
Access to GUM clinics within 48 hours 40
Chlamydia Screening 40
Under-18 teenage conceptions 41
Recommendations 42

**Accidents**

Hospital accident admissions 43
Falls and older people 43
Road Casualties 44
Recommendations 44

**Environment**

Housing and growth 45
Recommendations 46

**Health Protection**

Notifiable Diseases 47
Measles, Mumps and Rubella 48
Listeria Incident 48
Port Health 49
Clostridium difficile (C. difficile) Outbreak at Maidstone and Tunbridge Wells HNS Trust 49
Recommendations 50

**Emergency Planning**

Background 51
Priorities and Key Targets for 2007 51
Recommendations 51
Public Health in Kent

In November 2006, following reorganisation of the Primary Care Trusts in Kent, I became the Director of Public Health for Kent. This is a new, unique post, jointly appointed by Kent County Council, Eastern and Coastal Kent and West Kent Primary Care Trusts (PCTs). Public Health has of course been working apace under the previous structures and has a substantial amount of existing work on which to report. It is my great pleasure to present the first annual report of the Director of Public Health for Kent for the year 2006.

The responsibility for improving the health of the population is enshrined in the organisational objectives of West Kent PCT and Eastern and Coastal Kent PCT. Kent County Council (KCC) has demonstrated its commitment to Public Health, through the appointment to Cabinet of a lead for Public Health and in the adoption by Council of the Kent Strategy for Public Health. This has also been adopted by the boards of the two PCTs. We will consult the public and partners on future outcomes.

The Kent Strategy for Public Health identifies priority areas for action as follows:

- Reducing health inequalities – the gap in life expectancy between high and low wards in Kent is wide, at 17 years.
- Improving mental health and well-being of children – there are worrying trends in childhood obesity, mental health and educational achievement in some areas, as well as large numbers of children still living in poverty.
- Encouraging healthier lifestyles – preventable diseases like cancer and coronary heart disease are reducing but not as quickly in some communities as in others.
- Improving sexual health and reducing teenage pregnancies – are young people equipped to be making healthy choices in life?
- Ensuring more older people are able to live at home with chronic disease – there are rising proportions of older people in Kent and a range of increasing challenges which go with that fact.
- Reducing the levels of substance misuse – there are many public health issues arising from alcohol misuse. The strategy outlines the numerous action plans and targets that the public sector aspires to.
Why do we have a Public Health Report?

This is the first Kent-wide Public Health report of the modern era. It covers the major areas of relevance to the Kent Public Health Strategy, and it provides a ‘road map’ for developing health improvement. It is the first in a series of annual reports and as such does not, and cannot, cover every aspect of public health. Major needs assessment exercises in mental health, children’s and adult health will be developed in the near future and more information will emerge on these subjects. There are many aspects of Public Health not covered in this edition, such as special needs, sensory and other disabilities, wider environmental health topics like food safety, health and safety at work, disadvantaged minority issues, offender health, homelessness and more, which will need to be picked up in subsequent editions. Also there are mainstream areas which, while they have been touched on here, will require wider and more detailed attention in the future, such as mental health, social care and others. Finally, it is our intention to develop further our expertise in public health reporting so that we can investigate in more detail the costs in terms of potential years of quality of life lost to ill health, the costs of current care attributable to specific causes of ill health (such as smoking, alcohol, obesity, substance abuse, accidents, poor housing, pollution etc) and the effectiveness and comparative cost benefits (in both money and life years) relating to specific early interventions.

Meradin Peachey
Kent Director of Public Health
Demographics

Population

The total population of Kent County was almost 1.37 million in 2005, with marginally more people living in Eastern and Coastal Kent PCT than in West Kent PCT (52% of 48%). In Eastern and Coastal Kent PCT 18% were aged over 65, compared to 16% in West Kent and 17% in Kent County overall.

Table 1. Mid 2005 Resident Population Estimates

<table>
<thead>
<tr>
<th>Resident Area</th>
<th>2005 Estimate Number of Residents</th>
<th>Number of Residents Aged 65+%</th>
<th>Residents Aged 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern and Coastal Kent PCT</td>
<td>714,200</td>
<td>131,400</td>
<td>18.4</td>
</tr>
<tr>
<td>West Kent PCT</td>
<td>655,700</td>
<td>105,700</td>
<td>16.1</td>
</tr>
<tr>
<td>Kent County Area</td>
<td>1,369,900</td>
<td>237,100</td>
<td>17.3</td>
</tr>
</tbody>
</table>

At present the largest proportions of people resident in the county are aged between 35-44 and 55-59. There are lower proportions of people in the younger age groups and higher proportions in the older age groups than in England and Wales on average.
Projections from the Office of National Statistics predict dramatic increases in population size over the next 15 years, particularly in the elderly population. In Kent County the all-age population is set to increase by 4% by 2010 and 11% by 2020, whereas the over-65 population of this area is expected to increase by 9% by 2010 and a massive 36% by 2020, with the highest proportions of elderly residing in Thanet, Shepway and Dover Local Authorities. By 2020, 21% of the population of Kent will be aged 65+.

**West Kent population projections**

- The population of West Kent PCT is predicted to increase by 47,900 in the next 15 years (2006 to 2021).
- The growth rate is lower than the average for Kent & Medway but higher than the national average (7.3% compared to 10.8% and 6.7% respectively).
- The increase in the male population will be greater than the female population, as reflects regional and national trends.
- In West Kent PCT the male population is predicted to rise to 27,000 compared to an increase in the female population of 21,000.
- The older population will experience the greatest increase.
- In West Kent PCT the greatest rise will be in those aged 75+ (37.3%).
- There will be 18,600 more people aged 75+ in 2021.
- The population aged 0 to 44 is predicted to decrease slightly by 3,100 (0.8%).
The Office of National Statistics predicts a dramatic increase in the population over the next 15 years with the greatest increase in those aged over 65 years of age.

In Eastern and Coastal Kent PCT the all-age population is predicted to increase by 37,100 (5%) by 2010 and 106,400 (15%) by 2020.

The over-65 population of Eastern and Coastal Kent PCT is predicted to increase by 13,100 (10%) by 2010 and 54,000 (41%) by 2020.

In 2005, 18% of the local population were aged over 65. In 2020 this age group will constitute 23% of the population.

By 2020 the whole population will have increased by 4% and the over-65 years by 11%. These are greater than the increases expected for the County as a whole and particularly relate to increases in the proportions of elderly persons living in the Thanet, Shepway and Dover LAs.

Local population increases will be higher than in Kent County as a whole due to the large elderly population and their predicted increases in the areas of Thanet, Shepway and Dover Local Authorities.
Life Expectancy

Life expectancy at birth is given as the average number of years to be lived by a group of people born in the same year, if mortality at each age remains constant in the future. It is also seen as a measure of overall quality of life in an area, summarising the mortality at all ages. In West Kent PCT, life expectancy is 80.2 years old, higher than that of Eastern and Coastal Kent PCT at 79.2 and the resultant average for KCC at 79.7 years. Life expectancy in all local areas is higher than the national average.

Figure 5. Life Expectancy at Birth, 2003/05

The Kent Local Area Agreement (LAA) aims to reduce the disparity in life expectancy across the county. It concentrates on reducing the gap between the 20% of areas with the highest and the 20% of areas with the lowest life expectancy, currently a difference of 6.5 years. The target is to reduce this gap to 6 years by 2011.

Deprivation

The Index of Multiple Deprivation 2004 is a small area deprivation measure calculated as a combination of seven separate domains of relative deprivation and two supplementary indices:

- Income Deprivation
- Employment Deprivation
- Health Deprivation and Disability
- Education, Skills and Training Deprivation
- Barriers to Housing and Services
- Living Environment Deprivation
- Crime
- The Income Deprivation Affecting Children Index
- The Income Deprivation Affecting Older People Index

1 Measured in small areas within electoral wards termed ‘Lower Layer Super Output Areas’ (LL-SOAs)
The disparity between the East and West Localities and their levels of deprivation is clearly seen in figure 6. For many of the measures of deprivation West Kent PCT ranks on average as considerably less deprived than the Eastern and Coastal Kent PCT average. The exception to this is the domain of Barriers to Housing and Services. In the Eastern locality the majority of the population tends to be concentrated in areas such as Ashford and Thanet, weighting average scores toward those areas where affordable housing and local services and amenities such as food shops, post offices and GP practices are more accessible. For the Crime and Living Environment domain both East and West Kent experience similar levels of deprivation.

The rank for the Kent County as a whole is averaged from the East and West ranks. For all domains of deprivation the county ranks as less deprived than England as a whole, demonstrating the relative affluence experienced across the South East. However more localised need is highlighted in Eastern and Coastal Kent PCT which generally ranks as having equivalent levels of overall deprivation as England as a whole, but ranks as more deprived for the separate measures of Income, Employment and Educational deprivation, and Child Poverty.

Figure 6. Average Ranks of Deprivation by deprivation domain, 2004

Source: ODP Indices of Deprivation, 2004
Figure 7 below shows the levels of relative small area deprivation across the LL-SOAs of Kent. Areas of particular deprivation are seen in the urbanised centres of the main towns and in many coastal areas, whereas lesser deprivation tends to be found mainly in south-west Kent.

Figure 7. Index of Multiple Deprivation, 2004
## Health Status

### Key Health Indicators

<table>
<thead>
<tr>
<th>Target</th>
<th>West Kent PCT</th>
<th>Eastern &amp; Coastal Kent PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>The life expectancy at birth is higher in West Kent than Kent &amp; Medway and England (male life expectancy in West Kent is 77.9 compared to 77.1 and 76.7 in Kent &amp; Medway and England respectively; female life expectancy in West Kent is 81.7 compared to 81.2 and 81.0 in Kent &amp; Medway and England respectively)</td>
<td>Male life expectancy is 77 years, compared to 77.6 years in Kent and 76.5 years in England and Wales. Female life expectancy is 81.3 years, compared to 81.7 years in Kent and 80.8 years in England and Wales</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>The infant death rate is lower than the Kent &amp; Medway or national average (3.3 infant deaths per 1,000 live births in West Kent compared to 4.3 in Kent &amp; Medway and 5.1 in England)</td>
<td>The rate of deaths in infants under one year of age is higher in the PCT at 5.5 deaths per 1,000 live births than in the county as a whole (4.7) and in England and Wales (5.0). Around 10% of these are likely to be accounted for by Sudden Infant Deaths (SIDS). A proportion are attributable to maternal smoking</td>
</tr>
<tr>
<td>Teenage conceptions</td>
<td>The overall rate of teenage conceptions in West Kent is lower than the Kent &amp; Medway or national average (31.7 conceptions per 1,000 females aged 15-17 compared to 38.4 and 42.4 respectively). However, there are small areas within West Kent that exhibit rates considerably higher than the area average. 10 wards have teenage conception rates of 75.0 or more</td>
<td>In 2002/04, conceptions in girls aged under 18 occurred at a rate of 40.9 per 1,000 in Eastern and Coastal Kent PCT, higher than the observed rate of 37.0 per 1,000 in Kent County but lower than England and Wales with a rate of 42.2 per 1,000. High rates of teenage conceptions tend to occur in the more deprived urban and coastal areas</td>
</tr>
</tbody>
</table>
Mortality

Common causes of death in all ages in West Kent PCT

- The main causes of death in West Kent are circulatory diseases (CHD, stroke, other circulatory diseases) accounting for 37.7% of all deaths; cancers (26.3%); and respiratory diseases (13.2%).
- This reflects the Kent & Medway and national picture.

Figure 8. Causes of Death to Persons All Ages Resident in West Kent PCT, 2005

Most common causes of death, 2005, All Ages West Kent PCT area
(total deaths: 5,881 = 100%)

- CHD (928) 16%
- Other neoplasms (44) 1%
- Other circulatory diseases (619) 11%
- Strokes (672) 11%
- Diseases of the digestive system (272) 5%
- Diseases of the respiratory system (777) 13%
- Mental and behavioural disorders (192) 3%
- Diseases of the genitourinary system (95) 2%
- Suicide and Undetermined Intent (59) 1%
- Accidents (114) 2%
- All other Causes (399) 7%
- Malignant neoplasms (1547) 25%

Source: ONS, Annual District Death Extract (2005 registrns.)

Common causes of death in all ages in Eastern and Coastal Kent PCT

- Coronary Heart Disease (CHD) and stroke combined account for 28% of deaths, and one in four deaths are attributable to cancers.
- Respiratory diseases cause 16% of all-age deaths in the area.
- This reflects the Kent & Medway and national picture.
The first Annual Report for Kent of the Director of Public Health - summary

Figure 9. Causes of Death to Persons All Ages Resident in Eastern and Coastal Kent PCT, 2005

Most common causes of death, 2005, All Ages Eastern and Coastal Kent PCT area (total deaths: 5,881 = 100%)

- Diseases of the respiratory system (1253) 16%
- CHD (1442) 18%
- Other neoplasms (57) 1%
- Stroke (804) 10%
- Malignant neoplasms (2033) 26%
- Other Circulatory Diseases (750) 9%
- Suicide and Undetermined Intent (79) 1%
- Accidents (192) 2%
- Mental and behavioural disorders (221) 3%
- Diseases of the digestive system (430) 5%
- All other Causes (430)
- Diseases of the genitourinary system (151) 2%
- Diseases of the nervous system (191) 2%
- Mental and behavioural disorders (221) 3%
- Diseases of the digestive system (430) 5%
- All other Causes (430)

Source: ONS, Annual District Death Extract (2005 registrns.)

Disease morbidity

- The prevalence of the following conditions in West Kent PCT is higher than the Kent & Medway average: cancer*, asthma, stroke/TIA, hypothyroidism*
  *(the prevalence of these conditions is also higher than the national average)
- The prevalence of the following conditions in Eastern & Coastal Kent PCT is higher than the Kent County Council average: hypertension, diabetes, coronary heart disease, COPD and epilepsy.

Figure 10. Unadjusted disease prevalence taken from primary care disease registers, 2005/06
Lifestyle behaviours

- West Kent PCT has a lower estimated prevalence of smoking and obesity than Eastern and Coastal Kent PCT and Kent County, and a higher estimated prevalence than Eastern and Coastal Kent and Kent County of both adults and children eating their 5-a-day.
- In 2000-02 it is estimated that 22.8% of residents in West Kent PCT smoked, and 22.0% were obese.
- More children than adults in West Kent PCT achieved the aim of eating the recommended 5 portions of fruit and vegetables daily (37.4% compared to 26.5%).
- The prevalence of binge drinking was similar in both West Kent and Eastern and Coastal Kent PCTs and Kent county as a whole (West Kent PCT 14.6%, Eastern and Coastal Kent PCT 14.1%, Kent County 14.3%).

Progress towards Our Healthier Nation Mortality Targets

In 1999, the ‘Our Healthier Nation’ white paper (DH) set targets to reduce mortality rates for some of the most common causes of death. The following targets are to be achieved by 2010:

- Reduce deaths from circulatory disease, in those aged under 75, by 40%
- Reduce deaths from cancers, in those aged under 75, by 20%
- Reduce deaths from accidents by 20%
- Reduce deaths from intentional self-harm (suicides) by 20%

Progress against these targets are summarised in the table below:

<table>
<thead>
<tr>
<th>Target</th>
<th>West Kent PCT</th>
<th>Eastern &amp; Coastal Kent PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory disease</td>
<td>The age-standardised mortality rate is 72.9 deaths per 100,000 population. This is lower than the average for Kent &amp; Medway (81.1) and England (89.6). This rate is currently above the OHN target for West Kent PCT which is 72.5. Although rates have fluctuated over the last 5 years there has been a general reduction in mortality and the PCT is progressing towards this target</td>
<td>Circulatory disease mortality trends show a steady decrease from the 1995/97 baseline in the PCT, across the county and in the country as a whole. PCT rates for circulatory disease mortality are higher than in the county. A further reduction of 5.8% from the 2005 mortality rates for CHD will ensure that the 2010 target is reached within the PCT</td>
</tr>
</tbody>
</table>
Cancers

The age-standardised mortality rate is 116.8 deaths per 100,000 population. This is lower than the average for Kent & Medway (119.7) and England (118.8). This rate is currently above the OHN target for West Kent PCT which is 100.7. However, there has been a consistent reduction in cancer mortality rates over the last 5 years and considerable progress towards the target has been achieved.

Cancer mortality trends show a steady decrease from the 1995/97 baseline in the PCT, across the county and in the country as a whole. PCT rates for cancer mortality are higher than in the county. A further reduction of 1% from the 2005 mortality rates for cancer will ensure that the 2010 target is reached within the PCT.

Accidents

The age-standardised mortality rate is 15.1 deaths per 100,000 population. This is lower than the average for Kent & Medway (16.5) and England (15.9). This rate is currently above the OHN target for West Kent PCT which is 10.7. Mortality rates have fluctuated over the last 5 years and a considerable reduction will be required to achieve the target by 2010.

Accident mortality rates have remained fairly stable since the 1995/97 baseline, with only a slight downward trend. Rates of mortality from accidents are higher in the PCT than in the county and the country as a whole. A further reduction to accidental death rates of 9.1% is required in the PCT to reach the 2010 target.

Suicide and intentional self-harm

The age-standardised mortality rate is 8.8 deaths per 100,000 population. This is higher than the average for Kent & Medway and England (both 8.6). This rate is currently above the OHN target for West Kent PCT which is 5.9. The upward trend in deaths from intentional self-harm seen in previous years was reversed in 2005. However a considerable further year on year reduction will be required to achieve this target by 2010.

Suicide and undetermined injury account for only small numbers of deaths and so dramatic reductions are difficult to achieve. Currently the PCT needs to achieve a reduction of 19.6% from the 2005 rate of suicide in order to reach target by 2010. Suicide rates within the PCT are higher than in the county and the country as a whole.

<table>
<thead>
<tr>
<th>Target</th>
<th>West Kent PCT</th>
<th>Eastern &amp; Coastal PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancers</td>
<td>The age-standardised mortality rate is 116.8 deaths per 100,000 population.</td>
<td>Cancer mortality trends show a steady decrease from the 1995/97 baseline in the PCT,</td>
</tr>
<tr>
<td></td>
<td>This is lower than the average for Kent &amp; Medway (119.7) and England (118.8).</td>
<td>across the county and in the country as a whole. PCT rates for cancer mortality are</td>
</tr>
<tr>
<td></td>
<td>This rate is currently above the OHN target for West Kent PCT which is 100.7.</td>
<td>higher than in the county. A further reduction of 1% from the 2005 mortality rates for</td>
</tr>
<tr>
<td></td>
<td>However, there has been a consistent reduction in cancer mortality rates over</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the last 5 years and considerable progress towards the target has been achieved.</td>
<td></td>
</tr>
<tr>
<td>Accidents</td>
<td>The age-standardised mortality rate is 15.1 deaths per 100,000 population.</td>
<td>Accident mortality rates have remained fairly stable since the 1995/97 baseline, with</td>
</tr>
<tr>
<td></td>
<td>This is lower than the average for Kent &amp; Medway (16.5) and England (15.9).</td>
<td>only a slight downward trend. Rates of mortality from accidents are higher in the PCT</td>
</tr>
<tr>
<td></td>
<td>This rate is currently above the OHN target for West Kent PCT which is 10.7.</td>
<td>than in the county and the country as a whole. A further reduction to accidental death</td>
</tr>
<tr>
<td></td>
<td>Mortality rates have fluctuated over the last 5 years and a considerable</td>
<td>rates of 9.1% is required in the PCT to reach the 2010 target</td>
</tr>
<tr>
<td></td>
<td>reduction will be required to achieve the target by 2010</td>
<td></td>
</tr>
<tr>
<td>Suicide and intentional</td>
<td>The age-standardised mortality rate is 8.8 deaths per 100,000 population.</td>
<td>Suicide and undetermined injury account for only small numbers of deaths and so</td>
</tr>
<tr>
<td>self-harm</td>
<td>This is higher than the average for Kent &amp; Medway and England (both 8.6).</td>
<td>dramatic reductions are difficult to achieve. Currently the PCT needs to achieve a</td>
</tr>
<tr>
<td></td>
<td>This rate is currently above the OHN target for West Kent PCT which is 5.9.</td>
<td>reduction of 19.6% from the 2005 rate of suicide in order to reach target by 2010.</td>
</tr>
<tr>
<td></td>
<td>The upward trend in deaths from intentional self-harm seen in previous years</td>
<td>Suicide rates within the PCT are higher than in the county and the country as a whole.</td>
</tr>
<tr>
<td></td>
<td>was reversed in 2005. However a considerable further year on year reduction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>will be required to achieve this target by 2010</td>
<td></td>
</tr>
</tbody>
</table>

Health Inequalities

Whilst Kent’s deprivation indicators are better than England as a whole, they are below average as regards many parts of the South East region. West Kent reflects the fact that it is in the majority made up of prosperous commuter communities, enjoying good health status. There are, however, significant areas of relative deprivation, and thus poor health, associated with some of the Thames-side areas in the west, though these may benefit from the Thames Gateway regeneration projects.

Larger concentrations of relative deprivation are found in the east of the county. In the north of Kent, the Swale area has been subject to major economic change affecting long-established employment patterns. This pattern is reflected in many seaside towns around the east Kent coast, especially Margate, Ramsgate, Dover, Folkestone and Herne Bay; and to a lesser extent in parts of Ashford and the City of Canterbury. However, the economy is often resilient and highly flexible.
Nevertheless, there remain damaged communities, families, individuals and areas with concentrations of lower socio-economic status caused by fundamental economic change, which will take years to rebuild. Such communities tend to demonstrate: higher levels of family breakdown; unemployment and dependency on state benefits; educational failure or underachievement; drug, substance and alcohol misuse; crime; depressive illness; suicide; rent arrears; homelessness; and low-income single-parent families. These features can be indications of poorer life quality, poorer states of health and ultimately shorter lives.

In addition, the coastal part of Kent is attractive as a retirement area. With the increase in pensioner poverty and the changing demographic structure, which means there will be more older people relative to the population as a whole, this will provide a further challenge to reducing health inequalities.

**Coastal Deprivation**

Sixty per cent of electoral wards with the lowest life expectancy in the South East Region are located in coastal cities and towns and in Kent these include Dover and Thanet. In these wards, life expectancy is substantially below the regional average and other indicators of health are significantly worse than the regional average. Some of the highest teenage pregnancy rates in the South East are also seen in coastal districts.

The House of Commons Communities and Local Government Committee report on coastal towns, published in early 2007, identified a lack of specific policies or initiatives for English coastal towns. While recognising the diversity of these areas, the Committee concluded that coastal towns are in need of focused government attention. In the South East, the Regional Public Health Group, the South Central Strategic Health Authority and South East Coast Strategic Health Authority are supporting the work of primary care trusts and local authorities to reduce health inequalities in the region’s coastal cities and towns. The South East England Development Agency has published a coastal strategy and local development programmes such as Dover Pride are being developed to address many of these issues.

**Life Expectancy in Coastal Towns**

Average life expectancies for males and females in Kent are 77.6 years and 81.7 years respectively. Life expectancies for coastal town dwellers are substantially lower, as can be seen in figure 11.
A number of key themes have evolved from the Local Strategic Partnerships (LSPs) and thematic groups are established to take forward strategies and associated plans on the basis of these. Themes include: Crime and Disorder Reduction Partnerships (now statutory groups), Health and Wellbeing, Children’s Trusts (expected to become statutory in the near future) and Environment and Regeneration.

PCTs and Local Authorities are now expected to commission services jointly as appropriate. One particularly important initiative for Public Health is the joint needs assessment that the Director of Adult Social Services and the Director of Public Health will carry out. The Local Area Agreement (LAA) will be the key mechanism that facilitates joint planning and delivery.

Kent County Council is responsible for the development of the LAA for Kent and has established the Kent Partnership to develop the plans and ensure implementation (Kent Partnership, 2005). The LAA in Kent contains 18 outcomes, and each outcome is led by a particular agency as part of the partnership working arrangements listed in the table overleaf.
### Examples of Success for Partnership working in Kent

Examples of successful partnership working with Kent County Council and Trading Standards include:

- **Working towards less salt** – this project has just started with some funding from the Food Standards Agency. It is a “workplace intervention” to reduce the amount of salt in foods supplied in workplaces and to provide employees with the knowledge and skills to choose lower-salt food options. Six workplaces in the County have agreed to take part. KSS (Kent Scientific Services) are also involved as they will be analysing meals for salt levels.

- **Trading Standards South East (TSSE)** – Kent Trading Standards works on joint projects with the other 19 authorities in the TSSE region. Health-related projects include:
  - Examining portion sizes and nutritional content of meals sold at tourist attractions
• Establishing the accuracy of pre-packed foods using the Food Standards Agency traffic light labelling
• Analysing foods for ‘hidden’ sources of sodium
• All analysis for these projects is undertaken by KSS.
• Underage sales – to reduce the accessibility of alcohol, tobacco products and solvents to young people under the age of restriction, through test purchase operations. The target premises are established through intelligence received from a number of partners, such as the police, Kent Drug and Alcohol Action Team, licensing officers at District Councils, Crime and Disorder Reduction Partnerships and schools. The Police also participate in the test purchase operations.

Other initiatives in partnership with Kent County Council include:
• Transport Accessibility – Kent County Council and Primary Care Trusts are working together, as part of the KCC Accessibility Strategy for Kent. Healthcare being brought closer to the home and into the community reduces the need for transport, making healthcare ‘greener’ and more sustainable.
• Outreach work with organisations in East Kent, such as East Kent Health Walks and the Women’s Institute, introducing older members of the community to Nordic Walking. This is particularly beneficial to people with posture and joint problems.

Providing Effective Healthcare

One of the areas where PCTs can influence health is to manage resources in such a way as to improve value for money; by doing so they can maximise the health gain in the population for every pound that is spent. By shaping the demand for healthcare it is intended that patients receive the right care, for the right condition, in the right place and at the right time. By maximising the way we do that, we also maximise the amount of resources available to spend on avoiding ill health in the first place.
Recommendations

- That the PCTs, with partners, enhance people’s decisions relating to their own health, through improving access to information which directs them to expert triage for people seeking medical opinion, and / or helps them modify their lifestyles, as appropriate.

- That PCTs and providers work towards the development of more streamlined access to out-of-hours care through better coordination of primary care, secondary care, the ambulance service and NHS Direct.

- That the PCTs continue to refine appropriate alternatives to acute care admission and common robust methods for evaluating their impacts across the health and social care economies. That initiatives to enhance communication be tested and implemented where positive.

- That the PCTs develop plans to improve palliative and end-of-life care in the community and consider monitoring this provision through measuring outcomes such as numbers of patients dying in hospital with one day admission vs. number of patients dying at home.

- That the Kent PCTs develop a comprehensive, coordinated needs assessment plan, as and where appropriate, with partners. That the components are coordinated to fit with strategic plans for care pathway planning, programme budgets, and service developments and redesign.

- That the NHS consider ways of addressing sub-classifications of activity in acute trusts to account for assessment/opinions requiring “zero length of stay” admission.

- That Commissioners (particularly Practice Based Commissioners), through PBC, PBR and care pathway management concepts, develop programmes of work which modify variations in practice, where appropriate. Such developments should work towards better use of practice profiles, which include using the advantage of direct access to practice systems as well as the application of expert epidemiological and analytical skills. Such developments should support the provision of alternative effective and efficient care pathways.

- That the Public Health service adopts methods for assessing the economic value of local burdens of hospital morbidity and other health service activity attributable to specific agents. Having identified in this report the health burden of hospital admissions due to smoking, we need to develop similar methodologies for premature loss of life and for other agents such as alcohol, accidents, etc. That the services prioritise the evaluation and promotion of effective interventions with which to modify these burdens and put them forward as programmes for adoption. That this be reflected in future Annual Public Health Reports.

- That Practice Based Commissioners continue to research and develop initiatives to re-provide increasing levels of effective care in the community.

- That plans for future use of community hospitals consider the definitions and classifications of their activity to make that comparable with hospital activity elsewhere.
Figure 12 indicates that income deprivation affecting children is more prevalent in the urbanised areas. There are 31 LLSOAs in West Kent PCT which rank among the 20% most deprived areas in England and 30 LLSOAs in Eastern and Coastal Kent in the 20% most deprived areas in England.

Figure 12. The Index of income deprivation affecting children by LLSOA, Kent County, 2004
Births

Over the last ten years the numbers of births across Kent as a whole and indeed in both PCT areas has been broadly consistent. There was a dip in the number of births in 2001 and 2002 but for the following three years the numbers appear to be approaching the established pattern of ten years previously.

The most notable trend for Kent as a whole and replicated in both PCT areas is the steady increase in the numbers of live births to mothers aged 35+. This is a reflection of social change with increasing numbers of planned births later in life in consequence both of the wish to establish careers and probably a product of increased housing cost.

Table 2. Numbers of Live Births by Age of Mother, Kent County, 1996-2005

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>1,039</td>
<td>1,160</td>
<td>1,172</td>
<td>1,370</td>
<td>1,092</td>
<td>1,114</td>
<td>1,024</td>
<td>1,022</td>
<td>991</td>
<td>1,086</td>
</tr>
<tr>
<td>20-34</td>
<td>12,782</td>
<td>12,697</td>
<td>12,470</td>
<td>11,740</td>
<td>11,253</td>
<td>10,955</td>
<td>10,940</td>
<td>11,198</td>
<td>11,328</td>
<td>11,425</td>
</tr>
<tr>
<td>35+</td>
<td>1,945</td>
<td>2,130</td>
<td>2,220</td>
<td>2,251</td>
<td>2,405</td>
<td>2,575</td>
<td>2,640</td>
<td>2,814</td>
<td>2,954</td>
<td>3,102</td>
</tr>
<tr>
<td>All ages</td>
<td>15,766</td>
<td>15,987</td>
<td>15,862</td>
<td>14,117</td>
<td>14,750</td>
<td>14,644</td>
<td>14,604</td>
<td>15,034</td>
<td>15,273</td>
<td>15,613</td>
</tr>
</tbody>
</table>

Infant Mortality

All types of child mortality – stillbirths, perinatal, neonatal and infant deaths – show more favourable rates in KCC than in England as a whole. However, the neonatal and infant mortality rates in Eastern and Coastal Kent PCT are higher than in England and Wales and it is only the lower rates from West Kent that ensures that the County rates are below the national average. None of the PCT mortality rates are significantly different from the England average.

Table 3. Stillbirth Rate, Perinatal, Neonatal and Infant Death Rate, 2005

<table>
<thead>
<tr>
<th></th>
<th>Eastern &amp; Coastal Kent PCT</th>
<th>West Kent PCT</th>
<th>Kent County</th>
<th>England &amp; Wales</th>
<th>England Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stillbirths</td>
<td>4.4</td>
<td>4.7</td>
<td>4.5</td>
<td>5.4</td>
<td>Foetal deaths occurring &gt;24 weeks gestation per 1000 births</td>
</tr>
<tr>
<td>Perinatal deaths</td>
<td>7.9</td>
<td>6.3</td>
<td>7.1</td>
<td>7.9</td>
<td>Stillbirths and deaths &lt;7 days per 1000 births</td>
</tr>
<tr>
<td>Neonatal deaths</td>
<td>3.8</td>
<td>2.6</td>
<td>3.2</td>
<td>3.4</td>
<td>Deaths &lt;28 days per 1000 live births</td>
</tr>
<tr>
<td>Infant deaths</td>
<td>5.5</td>
<td>4.0</td>
<td>4.7</td>
<td>5.0</td>
<td>Deaths &lt;1 year per 1000 live births</td>
</tr>
</tbody>
</table>
The first Annual Report for Kent of the Director of Public Health - summary

Low birthweight babies

The rate of babies born at less than 2.5kg in weight is consistent across the two PCTs and the County, all with a rate of 7.1 babies per 100 births. This is lower than the proportion of low birthweight babies born in England and Wales as a whole (7.9 per 100).

<table>
<thead>
<tr>
<th></th>
<th>Eastern &amp; Coastal Kent PCT</th>
<th>West Kent PCT</th>
<th>Kent County</th>
<th>England &amp; Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>General fertility rate</td>
<td>58.0</td>
<td>60.4</td>
<td>59.0</td>
<td>58.4</td>
</tr>
<tr>
<td>Low birthweight births</td>
<td>7.0</td>
<td>7.1</td>
<td>7.1</td>
<td>7.9</td>
</tr>
</tbody>
</table>

Limiting Long-Term Illness

Data from the 2001 Census show that within Kent County, 4.2% of all children have limiting long-term illness. It should be noted that limiting long-term illness is self-declared and thus not easily verifiable from other sources. The rate for Eastern & Coastal Kent at approaching 5% is significantly higher than in West Kent (3.6%). Rates of limiting long-term illness vary by housing type, children living in socially rented accommodation being nearly twice as likely to have LLTI as those in owner-occupied housing. Children of families in private rented accommodation comprise a higher percentage than those resident in owner-occupation. This latter pattern is consistent across both PCTs.

Children and Young People receiving care

The number of children and young people being supported by Kent Children’s Social Services at a single point in time (between March of each year shown) is illustrated in figure 13. Between 2002 and 2003, the number supported increased by over a third, but in recent years the number has remained relatively consistent. Note that the figures are rates per 10,000 population aged 0-17 years. In 2005 the under-18 population was 327,000, so the absolute numbers would have been 32.7 times the figure shown.
Figure 13. Rate of referrals per 10,000 persons 0-17 years, to Kent County Council's Children's Social Services.

The number of Looked After Children (LAC) aged 0-17 years in Kent is illustrated in figure 14. It is possible to see the number of LAC who have been placed in Kent by authorities outside of Kent, in addition to those who are looked after by Kent County Council. The numbers have remained relatively stable in the last two years.

Figure 14. LAC aged 0-17 years in Kent per 10,000 population aged 0-17 years (as at March each year)

The number of children in Kent who are on the Child Protection Register is shown in figure 15. The number of 0- to 17-year-olds on the Register has increased slightly between 2003 and 2006, though numbers are too small for this to be of any significance.
Conception rates

Relative to England and Wales, the Kent rate of under-16 conceptions has been consistently lower and there is a welcome downward trend greater than the somewhat marginal decline in England and Wales generally. There is a marginal reduction within the area served by West Kent PCT and quite a notable reduction in Eastern & Coastal Kent. Notwithstanding that the incidence is low and despite this encouraging pattern, the rates are still unacceptably high.

Table 5. Under-16 Conception Rates in Kent local authorities, 2001-2003 and 2002-2004

<table>
<thead>
<tr>
<th>Area</th>
<th>Under-16 Total Conception Rate per 1,000 Females Aged 13-15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001-2003</td>
</tr>
<tr>
<td>Ashford LA</td>
<td>7.0</td>
</tr>
<tr>
<td>Canterbury LA</td>
<td>6.9</td>
</tr>
<tr>
<td>Dover LA</td>
<td>6.2</td>
</tr>
<tr>
<td>Shepway LA</td>
<td>9.3</td>
</tr>
<tr>
<td>Swale LA</td>
<td>8.3</td>
</tr>
<tr>
<td>Thanet LA</td>
<td>11.2</td>
</tr>
<tr>
<td>Eastern and Coastal Kent PCT</td>
<td>8.2</td>
</tr>
<tr>
<td>Dartford LA</td>
<td>8.7</td>
</tr>
<tr>
<td>Gravesham LA</td>
<td>8.0</td>
</tr>
<tr>
<td>Maidstone LA</td>
<td>7.4</td>
</tr>
<tr>
<td>Sevenoaks LA</td>
<td>4.3</td>
</tr>
<tr>
<td>Tonbridge and Malling LA</td>
<td>5.6</td>
</tr>
<tr>
<td>Tunbridge Wells LA</td>
<td>6.1</td>
</tr>
<tr>
<td>West Kent PCT</td>
<td>6.6</td>
</tr>
<tr>
<td>Kent County</td>
<td>7.4</td>
</tr>
<tr>
<td>England and Wales</td>
<td>7.9</td>
</tr>
</tbody>
</table>

Source: Teenage Pregnancy Unit
Towards a Strategic Needs Assessment

A recently published UNICEF report (2007) on the wellbeing of children in the 21 richest countries recorded the UK as bottom in five out of six criteria, with the highest rates of poverty, poor health and low expectations. The data in this report is one building block towards a Strategic Needs Assessment to be completed later this year (2007) as part of the commissioning of children’s services under the leadership of the Kent Children’s Trust. A broad approach to the needs assessment will be made, notwithstanding a particular focus upon early years in the first instance (needs assessments will be required for subsequent years of the commissioning cycle), following the key precepts of the White Paper on Children - Every Child Matters (2003):

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic wellbeing

In addition, health services for children must be benchmarked against the eleven standards set out in the ambitious nine-year programme of the National Service Framework (NSF) for Children (2004).

Recommendations


- The Kent Children’s Trust and the Local Children’s Trust arrangements (as currently described) work top-down and bottom-up respectively on the identification of strategic child health needs.

- The PCTs continue to increase investment in specialist services that prevent ill-health and facilitate optimal child health development. There is some suggestion on the basis of the data in this report linking such investment with a decline in the rate of hospital admissions.

- The PCTs and all other relevant agencies mainstream their funding to Sure Start Children’s Centres and kindred prevention programmes. These need to be targeted at areas of the County where there is a preponderance of families and children of lower socio-economic status. Continued long-term investment in such programmes will enable equity of investment in children’s early years and promote more equal chances in life for all of Kent’s children.

- A campaign is managed involving both families and primary care professionals to optimise the take-up of MMR vaccination programmes in Kent.

- Specific services supporting Looked After Children, regardless of whether these are Kent children or otherwise, should be sustained and if necessary given further investment.

- Further studies into Looked After Children should be undertaken as this category of children is at greatest risk of low self-esteem, substance misuse, mental health problems, teenage pregnancy, criminality and poor employment patterns.
Older People

Population change

When the planned housing growth in Kent is taken into account, the growth rate in the 65+ age group in Kent over the next ten years is twice what would be expected from the ageing of the indigenous population alone. The ratio of those of working age (18 – 64) to those aged 65+ is expected to fall from 3.86 currently to about 2.6, potentially implying significantly fewer workers to support more older people. In West Kent PCT the greatest rise will be in those aged 75+ (37.3%) and there will be 18,600 more people aged 75+ in 2021. The over-65 population of Eastern and Coastal Kent PCT is predicted to increase by 13,100 (10%) by 2010 and 54,000 (41%) by 2020.

Table 6. Population change in Kent County from 2007 to 2020

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Population All</th>
<th>% Change</th>
<th>Population Male</th>
<th>% Change</th>
<th>Population Females</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-19</td>
<td>183</td>
<td>174.5</td>
<td>-4.6%</td>
<td>93.8</td>
<td>89.6</td>
<td>-4.5%</td>
</tr>
<tr>
<td>20-34</td>
<td>233.3</td>
<td>260.9</td>
<td>+11.8%</td>
<td>115.9</td>
<td>132.1</td>
<td>+14.0%</td>
</tr>
<tr>
<td>35-44</td>
<td>207.2</td>
<td>183</td>
<td>-11.7%</td>
<td>100.8</td>
<td>87.8</td>
<td>-12.9%</td>
</tr>
<tr>
<td>50+</td>
<td>507.7</td>
<td>629.8</td>
<td>+24.0%</td>
<td>235.8</td>
<td>300.7</td>
<td>+27.5%</td>
</tr>
<tr>
<td>65+</td>
<td>241.5</td>
<td>319.5</td>
<td>+32.3%</td>
<td>105.3</td>
<td>147.2</td>
<td>+39.8%</td>
</tr>
<tr>
<td>75+</td>
<td>117.4</td>
<td>152.4</td>
<td>+29.8%</td>
<td>45.8</td>
<td>66.8</td>
<td>+45.9%</td>
</tr>
</tbody>
</table>

Health of Older People

The percentage of people reporting a limiting long-term illness increases with age. In the South East region, around 26% of those in early old age (60 to 64), around 40% of those in middle old age (65 to 84 years) and just under 70% of the oldest old (those aged 85 and over) have a limiting long-term illness. There is considerable geographic variation in the reporting of limiting long-term illness.

The key long-term conditions that affect older people are dementia, arthritis, stroke and coronary heart disease. Figure 16 shows how the numbers of people with these conditions is likely to increase in Kent
over the next nine years. This predicts more than 15,000 extra people with mild and moderate forms of dementia and more than 10,000 extra people developing CHD.

**Figure 16. Predicted long-term conditions in people aged 65+ in 2015**

![Figure 16](image)

**Recommendations**

- The PCT and its partners should promote independence and engagement for older people by increasing the opportunities for them to stay involved in their communities and ensuring that older people are not admitted to hospital or residential care due to lack of appropriate housing or access to housing adaptations, assistive equipment or technology.

- The PCT and its partners should develop a comprehensive falls prevention programme.

- Promote material well-being and financial security for older people by enhancing learning and skills development and fairness in work in later life, and by increasing the uptake of welfare benefits, concessions and other financial benefits.

- Promote healthy active living programmes which promote mental health as well as physical health by improving access for older people to health promotion and mental health services, especially for those who are socially isolated, through the development of active ageing programmes.

- Develop commissioning frameworks for older people which ensure that joined-up health and social care services are provided across the South East to support independence and choice for older people and their carers who require support.

- Develop commissioning frameworks for older people with dementia, to address the special needs of that group, and their carers.

- Improve information provision and advice to older people to encourage healthy lifestyles, greater social inclusion and participation in community life.
In the South East region smoking prevalence has declined since 1980 for both men and women (SEPHO 2007). According to the Community Health Profiles 2006 (APHO and the Department of Health 2006), the prevalence of smoking in Kent was 24.6%, which is lower than the national average smoking prevalence of 25.8%. In Kent, the highest smoking prevalence rates are in Thanet and Swale, with 29.5% and 28.6% respectively. Tunbridge Wells and Sevenoaks have the lowest smoking prevalence rates in Kent with 20.7% and 19.6%. Prevalence rates for each Local Authority area and estimated prevalence rates per PCT area are shown in Figure 17.

Fig 17. Estimated proportion of adults who are smokers by geographical area, 2002

Source: Community Health Profiles 2006, APHO and Department of Health. © Crown Copyright 2006
Smoking and Deprivation

There is a strong relationship between deprivation and smoking in Kent indicating a positive correlation between ward level deprivation and smoking prevalence in Kent County Council area. Meaning that where deprivation is the greatest in Kent, smoking rates are the highest.

Figure 18. Correlation between Smoking & Deprivation

Sources: Deprivation scores from ODPM Index of Multiple Deprivation 2004; Smoking prevalence from ONS Synthetic Estimates of Lifestyle Behaviours 2000-02.

Hospital Admissions and associated costs

It is estimated that there are nearly 12,000 admissions to hospital each year in Kent which are the result of smoking. The vast majority of these are as a result of cancer and respiratory and circulatory diseases, with these three categories being responsible for 92% of all smoking-related admissions in 2005-06. The most prevalent disease resulting in admission was ischaemic heart disease, with 2,359 admissions in the year. Chronic obstructive pulmonary disease and lung cancer resulted in similar numbers of admissions.

It is estimated that the 12,000 smoking-related admissions to hospital in Kent cost £26 million in 2005/06 with 33% of cases occurring in residents aged 35-64. Respiratory diseases were the most expensive category, being responsible for 40% of the expenditure for smoking-related hospital admissions. Smoking-related admissions in Eastern & Coastal Kent comprised 53% of the KCC total and involved 51% of the expenditure, the corresponding figures for West Kent being 47% and 49% respectively. Greatest expenditure on these diseases was calculated to be in Thanet and Maidstone local authority areas, with nearly £2.8 million being spent in each area.
Tobacco Control and Stop Smoking services

The Kent Alliance on Smoking & Health (KASH) is a multi-agency alliance hosted by Eastern & Coastal Kent Primary Care Trust, carrying out work across the whole of Kent. The alliance consists of representatives from the Eastern & Coastal Kent and West Kent Stop Smoking Services, the 12 local authorities in Kent, Kent County Council Trading Standards, Kent County Council Education as well as other agencies dealing with tobacco-control issues.

Throughout 2006, the alliance partners continued to promote smoke-free public places and prepare for smoke-free legislation. Local Authorities set up smoke-free working groups and started to engage with local businesses to ensure the legislation was well publicised.

In 2006/2007 Stop Smoking Services in Kent helped 6,780 people to stop smoking (measured after four weeks); Eastern and Coastal Kent achieved 82% of their planned target, while West Kent achieved 65%. This was achieved by running specialist group and one-to-one interventions. The stop smoking services also work closely with GPs and pharmacists to provide a wide network of in-house support. Specialist support was also available for pregnant women and their families, provided in their homes and in other convenient locations. Stop smoking support was also available in workplaces, mental health settings, hospitals and prisons.

Recommendations

- More coordinated approach to promoting stop smoking services in Kent.
- More partnership work with Her Majesty’s Revenue and Customs.
- Promote Age of Sales legislation through Kent Alliance on Smoking & Health and liaise with Healthy Schools to ensure adequate support for young people in Kent.
- Continue to work with local authority partners to ensure the success of smoke-free legislation in Kent.
- A more coordinated approach to reduce smoking uptake in Kent looking at a wide range of measures.
Figure 19 shows the estimated proportion of the Kent population who are obese by local authority and PCT area taken from the ONS synthetic estimates of lifestyle behaviours. Swale and Dover are estimated to have the highest adult obesity rates. There is also a strong relationship between obesity and deprivation in Kent (as with smoking behaviour), with higher levels of deprivation related to higher levels of estimated obesity.

Fig 19. Estimated proportion of adults who are obese by geographical area, 2002


**Obesity Management programmes**

Programmes to address obesity across Kent have included the following:

- Healthy Start: the National Healthy Schools Programme engages everyone – staff, pupils, governors, parents and the wider community – in a whole-school approach that aims to improve educational achievement, health and emotional wellbeing, and make schools a safe, secure and healthy environment in which young people can learn and develop.
Sure Start Programme: offers one-stop support for childcare, early education, employment support, health advice etc with a targeted service for deprived communities. Provides advice and support to parents and parents-to-be to promote breastfeeding, good weaning, active play and healthy lifestyles in families with children aged 0 to 5.

Play: The Big Lottery Fund has made available £155 million to create, improve and develop children's play provision (in England) and develop innovative practice.

School Food Agenda: to invest in improving nutrition in school meals by revising both primary and secondary school meals standards, strongly considering nutrient-based standards, reducing the consumption of fat, salt and sugar, and increasing the consumption of fruit and vegetables and other essential nutrients. Subject to legislation, the new standards will be extended to cover food across the school day, including vending machines and tuck shops. Schools will be supported with new guidance on food procurement and improved training and support for school meal providers and catering staff.

School Fruit and Vegetable Scheme: to make all 4- to 6-year-old children in LEA-maintained infant, primary and special schools in England eligible for a free piece of fruit or vegetable every school day.

Recommendations

- The wide range of good practice being undertaken in Kent be sustained and evaluated so as to develop intermediate indicators which assure us that, over time, the good practice will impact upon the prevalence of obesity in Kent. While Kent is delivering on national targets and has funded many innovative pilots, particularly in areas of deprivation, it is important to assess the probability and degree of these providing a positive change to predicted future health patterns.

- As the PCTs are committed to investing in obesity prevention, the expected attributable morbidity prevented should be estimated and evaluated for outcomes.

- The benefits of effective partnership working be calculated and expressed in consolidation of existing partnerships and development of new ones to address the wider determinants of health and their impact on obesity.

- As we broaden our evidence-based practice to ensure that the most effective interventions are supported and resourced we estimate the effects of each on specific segments of the target population.

- We develop with our partners common aims and objectives, and ensure that we benchmark the shared information, knowledge and resources and set targets for improvement.

- Kent’s commitment to improving our population’s health through development and investment in changing our ‘obesogenic’ environment to reduce levels of obesity in children and adults, be summarised in plans and population targets.
Each year more than 250,000 people are admitted to psychiatric hospitals and over 4,000 people take their own lives. Mental health problems range from mild depression, stress and anxiety, to severe mental illness.

Eighty per cent of all mental health contacts in the NHS take place in primary care and between 30 and 50 per cent of those with Severe Mental Illness (SMI) have only their GP as a point of contact. People with Severe Mental Illness (SMI) who are looked after in Primary Care are now recognised as people who belong to the “long-term conditions” group of patients. Within Kent, patients are tracked to ensure that they receive regular health checks for blood pressure, weight gain, and medication side-effects.

Size of the problem

National data suggests that:

- Work-related stress affects about one in five workers or approximately 5 million people. Stress-related conditions are now the most common reported cause of sickness absence. 865,900 adults on Incapacity Benefit in England report their primary condition to be mental ill-health.
- One in 10 children under the age of 16 has a mental health problem.
- One in six adults at any one time has a mental health problem – maybe as many as nine million people are affected. Up to 670,000 people in the UK have some form of dementia – 5 per cent of people over 65 and up to 20 per cent of people over 80.
- Up to one in four consultations with a GP concern mental health issues.

Suicide Prevention

The latest overview of suicides and undetermined deaths across Kent shows that the suicide rate in Kent is slightly higher than the national average. During the three-year period 2003-2005, the average number of suicides per year in Kent was 130. The suicide rate for the West Kent PCT area is slightly above the national average, at 8.60 per 100,000 (the national average is 8.50 per 100,000). This suggests some cause for concern as an area of comparative affluence would be expected to fall below...
this figure. Moreover the rate in west Kent has risen slightly over the past four years. Dr Hamdi, who conducts a local audit of suicides in west Kent, has recommended attention at the early intervention and primary care stage, since two-thirds of suicides are not known to mental health services.

The suicide rate in the Eastern & Coastal Kent PCT area is also higher than the national average at 9.60 per 100,000; although this is up on the previous three-year rate, the overall trend in east Kent is falling rates.

**Recommendations**

It is recommended that:

- Advocacy for Mental Health issues becomes a major priority for the PCTs and KCC
- Partners develop comprehensive needs assessment for mental health
- Estimates of levels of specific mental illness across Kent are determined in order to refine services directly toward improved outcomes in adults and young people
- Subsequent Annual Public Health Reports pick up major themes in mental health on a regular basis
Drugs and Alcohol

Treatment in Kent

Access to drug misuse treatment is largely equal across the County, with the shortest waiting times for services such as prescribing now commonplace, in line with the national standard of 3 weeks. This is reinforced and strengthened by the current county-wide commissioning arrangements. Service provision is made up of access to advice and information, assessment, syringe exchange services, substitute prescribing, structured day care and structured psychosocial interventions; access is also provided, where appropriate, to specialist inpatient detox and residential rehabilitation. Access to specialist treatment within prisons is improving, with PCTs now responsible for healthcare services; this should continue to improve with the introduction of the Integrated Drug Treatment System, including additional financial resources.

Screening for alcohol misuse largely takes place in community GP practices, with much treatment still taking place within inpatient hospital settings. Community-based treatment for alcohol misuse available in Kent includes brief interventions, structured psychosocial interventions and community detox, with treatment currently guided by the Models of Care for Alcohol Misusers (Department of Health, 2006). Specialist inpatient detox is available for the first time where appropriate for residents of the whole county but access to community-based treatment is not, with access mostly available in East Kent. East Kent residents will also benefit from the delivery of a specialist locality based brief interventions service from November this year.

Trends for young people in drug and alcohol use in Kent

Table 7 shows the substances which young people accessing treatment services in Kent identify as their primary substance of concern. In the vast majority of cases this will be the young person using the substance themselves, but in some cases referrals are due to the young person’s concern around another person’s drug use, eg. their parent’s usage.
Table 7. Substances misused by young people accessing DAAT services in Kent

<table>
<thead>
<tr>
<th>Age</th>
<th>Alcohol</th>
<th>Crack cocaine</th>
<th>Drug Free</th>
<th>Ecstasy</th>
<th>Heroin</th>
<th>Prozac</th>
<th>Solvents</th>
<th>Cannabis</th>
<th>Cocaine</th>
<th>Amphetamines</th>
<th>Methadone</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>12</td>
<td>4</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>13</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>14</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>15</td>
<td>39</td>
<td>2</td>
<td>1</td>
<td></td>
<td>1</td>
<td>28</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>72</td>
</tr>
<tr>
<td>16</td>
<td>51</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td>49</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>104</td>
</tr>
<tr>
<td>17</td>
<td>58</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>42</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>111</td>
</tr>
<tr>
<td>18</td>
<td>66</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>41</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>115</td>
</tr>
<tr>
<td>Total</td>
<td>238</td>
<td>1</td>
<td>3</td>
<td>6</td>
<td>8</td>
<td>9</td>
<td>175</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td></td>
<td>449</td>
</tr>
</tbody>
</table>

Feedback from practitioners across the county concurs with the view that it is cannabis and alcohol that present the greatest problems for young people. With regards to cannabis, young people are reporting to practitioners increased cases of contaminants as well as associated health, financial and legal problems.

Gaps in service provision

The year 2007–2008 has already seen a substantial cut in the pooled budget for young people’s drug services. The Drug Strategy ends in April 2008 and there is as yet no indication of what the expectations of central government are of young people’s drug treatment services and whether additional funds will be available to fund existing or additional services. Indications have been given that Tier 2, targeted prevention, will not be funded.
The first Annual Report for Kent of the Director of Public Health - summary

**Recommendations**

- The county-wide access to drugs treatment services should be maintained, ensuring drug users, particularly injecting drug users, are engaged and retained in treatment, with its attendant health gains and savings for the health sector.

- Access to alcohol treatment should be improved to ensure equality of access across the County.

- Access to screening and testing for Hepatitis C should be improved for injecting drug users, to increase numbers in treatment and encourage risk reduction by those without a positive diagnosis.

- Access to vaccination for Hepatitis A and B for drug and alcohol misusers should be improved, to reduce transmission and infection.

- Multiple systemic interventions with family work: NICE guidelines support the need for systemic work with families of vulnerable young people.

- Identification of children and young people of families who misuse substances and services that meet that need, such as the Sunlight Project.

- Specialist intervention for 16- to 25-year-olds with problematic use.

- Specialist supported accommodation for young people with problematic substance misuse needs.

- Proactive outreach work with young people who are less likely to access services, ie young people from ethnic minority communities and young people who identify as lesbian, gay or bisexual.

- Intervention options should be considered for pilot studies in Kent.
chapter 10

Sexual Health

Genitourinary Medicine (GUM) services

**West Kent**

Services are provided in three locations within West Kent – Dartford, Tunbridge Wells and Aylesford.

The Renton Clinic in Dartford provides a full range of HIV and STI services and some supportive contraceptive advice. It is based at Darent Valley Hospital and is one the largest units in Kent and Medway (26 doctors and 76 nurse sessions a week). There are about 8,000 attendances a year. Demand is expected to rise, with an increased awareness of STIs and in particular the introduction of Chlamydia screening. The clinic aims to minimise the number of follow-up attendances and over the last year has made significant strides in this area. However, maintaining this is dependant on access to treatments that do not need further specialist intervention or a handover to primary / community services.

New strategies are needed both to tackle the increase in attendances and secure sufficient capacity so that the 48-hour target can be achieved by 2008. Analysis of attendances shows that at least 2,000 of these are for sexual health screens, indicating potential for these to be managed in a less acute environment and therefore to free up capacity.

Maidstone and Tunbridge Wells NHS Trust also provide GUM services. Clinics are situated at Kent and Sussex Hospital in Tunbridge Wells and Preston Hall in Aylesford. Eight sessions are currently provided each week, five at Kent and Sussex and three at Preston Hall. These services also provide the full range of GUM services but demand outstrips resources and current waiting times are 10 days at both sites. There are commissioning issues resulting from the lack of tariff arrangements and lack of investment in premises and services generally.

**East Kent**

The GUM service has developed over many years on an ad hoc basis, driven by changes in the sexual attitudes and behaviours of the public and the NHS restructuring programme. The advent of HIV, increasing levels of STIs and the rise in teenage pregnancy have all had their part to play in raising the profile of the service. Recent targets and publicity have helped to concentrate effort, direct attention and increase funding to what essentially were ‘Cinderella services’.
The East Kent Sexual Health Strategy outlines a plan to create a Sexual Health Service on a hub and spoke model. It is intended that the Kent and Canterbury Hospital site will provide an extended and refurbished hub which will be open five or six days a week providing an ‘under one roof’ facility. Subsidiary hubs will be located in centres of population across East Kent, Sittingbourne, Thanet, Dover, Folkestone and Ashford.

Plans for the hub at the Kent and Canterbury site have been agreed and work will commence in the autumn of this year. Services including contraceptive, young people’s, GUM, HIV and psychosexual services were recently brought together under one management structure in the Operations Directorate of Eastern and Coastal Kent PCT, thus creating the Eastern and Coastal Kent Sexual Health Service.

**Access to GUM clinics within 48 hours**

Data from the Health Protection Agency has shown that both West and East Kent clinics have improved the percentage of patients seen within 48 hours, though West Kent was still well below 60% in the last quarter of 2006/07. The waiting times in Renton clinic in West Kent are now within the GUM access targets – offering appointments within 48 hours of contacting the service. Current waiting times at the Maidstone and Tunbridge Wells NHS Trust services are 10 days.

![Figure 20. Health Protection Agency survey of patients seen within 48 hours in GUM in Kent](image)

**Chlamydia Screening**

Figure 21 shows the provisional data on the proportion of young people screened for Chlamydia which will be reported to the Health Protection Agency. This early information shows that Eastern and Coastal PCT is already screening a higher proportion than is seen nationally.
Figure 21. Chlamydia screening – proportion of people aged 15 to 24 years screened in 2006/07

![Bar chart showing Chlamydia screening proportions](chart.png)

National Screening Programme data as of 28 June 2007 and may not reflect all Chlamydia screens performed but as yet unreported to Health Protection Agency

**Under-18 teenage conceptions**

The highest number of teenage pregnancies occur in the east of Kent. Dover, Shepway and Canterbury have been very successful in reducing teenage conceptions, with rate reductions of between 31 and 26% since inception of the Teenage Pregnancy Strategy. Sustaining reductions in Thanet and Swale has been more challenging, and although both have attained decreases at some point in the strategy, the increases in both districts override any decreases achieved (Thanet increase of 6.8 and Swale increase of 18%).

Sevenoaks has had an excellent reduction in teenage conceptions of 26%, however the majority of districts in west Kent have found it difficult to prioritise teenage pregnancy issues and have only more recently started to implement the strategy. Dartford, although having only an overall decrease of 2%, has shown the best reductions over the last two years. Maidstone has had a very marginal decrease and overall demonstrates an increase in conception rate since the strategy’s inception of 13%. West Kent PCT as a whole demonstrates static rates but the reconfiguration of the PCT is proving to be advantageous to the strategy with regard to the joint commissioning of posts and service provision.
## Recommendations

There is a need for:

- An increase in accessibility of sexual health services, particularly Chlamydia screening
- Developing better Personal Relationships and Sex Education (PRSE) within Personal, Social and Health Education Programmes (PSHE)
- Services to work towards a network approach offering signposting to other sexual health services, to standardize service provision and promote sharing of good practice
- Developing one-stop community genito-urinary medicine (GUM) clinics to meet 48-hour targets
Accidents

Hospital accident admissions

The hospital admission rates for serious accidental injury across West Kent Local authorities vary considerably. Dartford and Gravesham have the highest rates but these are in line with the Kent, South East and England average, while Maidstone LA has the lowest rates. Rates for males are marginally higher than for females. Apart from Dartford and Gravesham, all other Local Authorities in West Kent are below the Our Healthier Nation 10% target reduction on the 1995/96 baseline. The target does not have to be met until 2010, so current initiatives and programmes must continue to ensure that progress made so far is sustained.

The hospital admission rates from serious accidental injury in East Kent Local Authorities are quite similar. It would seem that rates are generally higher in Ashford and Thanet and lowest in Canterbury. Although rates are higher in East Kent than West Kent, they are not significantly above the England average. Local Authorities in East Kent still have some work to do before reaching the Our Healthier Nation 10% target reduction on the 1995/96 baseline by 2010.

Falls and older people

The overall outcomes of falls prevention strategies are improving but the picture is complex. While the rate of falls-related admissions for over-65s dropped slightly in Eastern & Coastal Kent PCT in 2005/06, it increased quite sharply in West Kent PCT from a lower base to above that of East Kent. However, over the three-year period 2003/04 to 2005/06, West Kent had a lower rate of admissions.

Both West Kent and East Kent had reductions in falls-related fracture of femur (West Kent had bigger reductions and a lower rate), and neck of femur fracture (West Kent lower rate) among people aged 75+. A possible explanation for the lower rates in West Kent, while rates for all falls-related admissions were higher, could be that there is more assessment and prescribing for primary and
secondary prevention of osteoporosis, or more weight-bearing strength and stability exercise for those at falls/osteoporosis risk, leading to a reduction in fractures when falling.

**Road Casualties**

On the roads for which Kent County Council and the Highways Agency are responsible, over 6,000 people are injured each year, and of these around 750 people are killed or seriously injured (KSI). Compared with the 1994-98 average, there has been a 37% reduction in the number of people killed and seriously injured; a 50% reduction in the number of children killed and seriously injured; and a 4% reduction in slight casualties. This reduction is comparable with national figures.

This current year is crucial, as the target of reducing KSI casualties, including those on motorways and trunk roads, by 40% compared with the 1994-1998 average, needs to be met and sustained by the end of 2007 to achieve the Public Service Agreement 2 target. KCC has established working relationships with a number of local partners in order to provide safer roads for Kent's residents.

**Recommendations**

It is recommended that:

- A body to coordinate and oversee injury prevention in Kent is established.

- Action is taken to enhance data and surveillance and workforce capacity to reduce directly the burden of ill-health from accidental injuries.

- Action is taken to enhance data and surveillance and workforce capacity to reduce directly the burden of unintentional injuries to children.

- Kent Public Health develops options for leadership and processes to address this and other areas of accident prevention.
Environment

Housing and growth

About a quarter (26.4%) of all housing in Kent is rented, with just over half of that (55.7%) rented in the social sector and the remainder (44.3%) rented from private landlords, etc. Overall the percentage of homes with poor household amenities is far lower than the national average (8.7%), though similar rates are seen in Dover and Swale and the highest percentage is in Thanet, at almost 10% of all housing stock.

Kent County Council Supporting People Partnership funds housing-related support to a wide range of vulnerable people to enable them to live independently in the community. Housing-related support is provided via accommodation-based services (including sheltered accommodation) and as floating (temporary) housing-related support for vulnerable people. New accommodation-based services to be commissioned are services for young people at risk, people with mental health problems, people fleeing domestic abuse and people misusing substances. New floating support services to be commissioned are services for people living with HIV/AIDS, gypsies and travellers, ethnic minority communities in North Kent, and for the Rough Sleepers Outreach and Resettlement Service.

Kent contains two of the government’s “growth” areas, in Ashford and the Thames Gateway. Two-thirds of proposed housing growth will be needed to meet the growth in Kent’s own population, including first-time buyers and the increasing number of people living alone. The remaining third is to meet predicted migration into Kent (mostly from elsewhere in the UK).

Air Quality

The Kent and Medway Air Quality Monitoring network was formed in 1997 to ensure a co-ordinated approach to air quality monitoring and reporting across the county. The 2006 annual report uses monitoring results from the network to describe how pollution levels compare to national standards and guidelines, describe the occurrence of pollution episodes over the past year, and present trends in concentrations since 1997.
Recommendations

- That the development of Joint Strategic Needs Assessments will be used to influence both local and regional planning processes (including the Local Development Frameworks) in order to plan appropriately for future population needs.

- In addition to this, that Health Impact Assessments are routinely undertaken as part of planning new housing developments and regeneration projects.

- Measure and monitor the links between health, housing and social care in order to reduce inequalities, improve people’s ability to stay in their own homes, and improve services that are available to them.

- To identify opportunities for preventing exacerbations of airways diseases (asthma, Chronic Obstructive Pulmonary Disease, etc) arising from early warnings generated through surveillance of Kent’s air quality.
## Notifiable Diseases

**Table 8. Notifiable Diseases identified in Kent in 2006**

<table>
<thead>
<tr>
<th></th>
<th>Dysentry</th>
<th>Food Poisoning</th>
<th>Malaria</th>
<th>Meningitis</th>
<th>Meningococcal Septicaemia (without meningitis)</th>
<th>Scarlet Fever</th>
<th>Viral Hepatitis</th>
<th>Whooping Cough (Pertussis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>0</td>
<td>251</td>
<td>4</td>
<td>13</td>
<td>0</td>
<td>10</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Canterbury</td>
<td>3</td>
<td>252</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Tunbridge Wells</td>
<td>5</td>
<td>207</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>16</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Ashford</td>
<td>5</td>
<td>190</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>8</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Sevenoaks</td>
<td>2</td>
<td>174</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>9</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Thanet</td>
<td>4</td>
<td>173</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Swale</td>
<td>4</td>
<td>125</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>10</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Shepway</td>
<td>3</td>
<td>118</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Dover</td>
<td>1</td>
<td>111</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tonbridge &amp; Malling</td>
<td>0</td>
<td>68</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Dartford</td>
<td>2</td>
<td>58</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maidstone</td>
<td>0</td>
<td>49</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>7</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Gravesham</td>
<td>4</td>
<td>47</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
<td><strong>1823</strong></td>
<td><strong>6</strong></td>
<td><strong>42</strong></td>
<td><strong>24</strong></td>
<td><strong>88</strong></td>
<td><strong>27</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>
Measles, Mumps and Rubella

There were no laboratory-confirmed cases of measles in Kent for over four years until March 2006, when saliva testing on a 4-year-old child confirmed the disease. The child was unvaccinated and had links to both the travelling community and a local prison, where additional cases were later identified and confirmed by the laboratory.

Following an outbreak of mumps in 2004 affecting 6 first-year students at the University of Kent at Canterbury, a mass vaccination programme was arranged. A total of 3,360 students and staff were vaccinated with the MMR vaccine. By the end of March 2004, 24 cases had been diagnosed, 10 of which were later laboratory-confirmed from saliva testing. Following the outbreak, all general practitioners, health visitor managers and all university medical staff in Kent were contacted by letter requesting that they be vigilant about mumps. As the number of cases of mumps being reported both locally and nationally had increased dramatically, mass vaccination sessions were also set up in November and December at a number of educational venues across Kent.

Uptake of the MMR vaccination in children aged 2 years was over 80% in both West and East Kent PCTs in 2006, with the booster uptake at 5 years lower than 80%. These rates are similar to regional and national figures.

Listeria Incident

In March 2007, the Health Protection Agency (HPA), the Food Standards Agency (FSA), and the NHS worked together to alert consumers about sandwiches possibly contaminated with Listeria monocytogenes. The sandwiches were supplied by a Kent-based company to a range of establishments in Kent, Sussex, Essex, Middlesex, Surrey and Greater London, including schools, hospitals and local authorities, before the problem became known.

This was declared an HPA level three incident on day five, and was led by KHPU and HPA South East on behalf of Local and Regional Services (LaRS). A detailed risk
assessment was undertaken. Press releases were issued. The incident was covered widely by the media without undue public alarm. Hospital clinicians and GPs were alerted. Clinicians were advised to send samples from any confirmed diagnoses of listeriosis to the Centre for Infections (CfI) for typing. Since the beginning of the incident, 19 cases of listeriosis in London and the South East have been reported to CfI. So far, there is only one possible link to the consumption of the contaminated sandwiches.

**Port Health**

Port medical inspections in Kent are carried out by an associate specialist who is helped out of hours by GPs employed on a sessional basis. The work of the unit is supported by two port health nurses and a port health assistant. The work of this team involves both visits to the port and telephonic advice covering a 24 hour service. In 2006 there were 213 referrals to the unit.

**Clostridium difficile (C. difficile) Outbreak at Maidstone and Tunbridge Wells HNS Trust**

Between October 2006 and April 2007 the Healthcare Commission carried out an investigation to look into outbreaks of *C. difficile* at Maidstone and Tunbridge Wells NHS Trust and to assess the care provided to patients with this infection. It also considered whether the trust’s systems and processes for the identification, prevention and control of infection were adequate. A report was produced in October 2007 which concluded that, at the time of the first outbreak, in 2005, the trust had no effective system for surveillance of *C. difficile* and consequently failed to identify the outbreak that involved 150 patients. When the second outbreak was declared in April 2006, patients were cared for on a number of wards until an isolation ward was established in the August of that year.

The clinical management of *C. difficile* infection in the majority of the patients fell short of an acceptable standard in at least one aspect of basic care. Some patients, who might have been expected to make a full recovery from the condition for which they were admitted, were prescribed broad-spectrum antibiotics during their stay in hospital, contracted *C. difficile* and some died. The infection control team was not managed properly and standards of cleanliness and infection control were not good.

The report stressed the need for appropriate antibiotic prescribing, effective isolation, the importance of scrupulous cleanliness and hygiene, and the need to provide a high standard of care for patients infected with *C. difficile*, including having adequate staff.

A previous Healthcare Commission investigation into an outbreak of *C. difficile* reported in July 2006 (after the outbreaks in Maidstone & Tunbridge Wells NHS Trust). Because of differences in the ways in which death certification is completed, the HCC developed a method for estimating deaths from this condition, which involved a detailed review of a sample of case notes and related certification, from which they extrapolated figures.

Laboratory results of isolates of *C. difficile* infection in the faeces in the over-65s have been reported
nationally to the Health Protection Agency since January 2004. These results are referred to in greater
detail in the larger reference version of the report available at www.kentphil.nhs.uk. Local targets for C.
difficile have been established since the period covered by this report.

Since the C. difficile outbreaks, all Kent Trusts have taken significant steps through action plans to
bring down the incidence of infections and to make sure that proper processes are in place for
managing any future outbreaks. Conditions have improved as a result of these actions and monitoring
and C. difficile incidence is now lower than in many parts of the country.

**Recommendations**

It is recommended that:

- The evaluation, promotion and enhancement of effective hand hygiene and of prudent antibiotic
  prescribing at all points of prescribing should be carried out across the health care system.

- Appropriate isolation of patients and use of personal protective equipment wherever indicated.

- All health care professionals should continue to promote the MMR vaccine and should actively
discourage parents from having their children vaccinated with single vaccines. Parents should
be provided with support and information in order to address their concerns.
chapter 14

Emergency Planning

Background

In the last two years there have been a number of developments in NHS resilience planning within Kent. These developments have been driven by the enactment of the Civil Contingencies Act in 2005, the production of updated Department of Health Emergency Planning Guidance, and finally by the restructuring of the NHS. The legislation and associated guidance were designed to ensure that key organisations and agencies are capable and practiced in their ability to manage major emergencies. The Civil Contingencies Act defines PCTs as category 1 responders. This places statutory duties on them which include:

1. Assessing the risk of emergencies occurring and using this to inform contingency planning.
2. Putting in place Emergency plans.
3. Putting in place Business Continuity Management plans.
4. Putting in place arrangements to warn, inform and advise the public in the event of an emergency.
5. Sharing information with other local responders to enhance coordination.
6. Cooperating with other local responders to enhance coordination and efficiency.

The Kent Emergency Response Management Team (ERMT) received 30 alerts in 2006 for incidents that could or would require emergency response from the NHS. These alerts included the activation of a Department of Health Level 3 and two Level 2 Heat Wave warnings, a fire in the Channel Tunnel with a declared Bi-National major incident, serious road traffic accidents, various fires, gas leaks, floods and power outages requiring evacuation/rest centres being opened to accommodate displaced/evacuated families.

Recommendations

- To review and publish an updated Kent Community Risk Register (CRR), undertake collaborative risk assessments for newly identified risks, monitor risks and identify where gaps exist in plans and take the necessary remedial actions in 2007.

- To develop a multi-agency annual programme of training and exercises with a view to maximising training opportunities. This programme will also include Table Top and Command Post exercises, at strategic level, with the Kent Resilience Forum (KRF) partners in response to new guidance on Mass Casualty and Pandemic Flu planning requirements, in 2007.


The preparation of this report has been made possible with the substantial contribution of the following:

Editorial Group

Meradin Peachey, Declan O’Neill, Del Herridge, Julian Barlow, Jill Rutland, Mark Chambers, Sarah Spencer, Yong Lee, Dominique Allwood, Andrew Scott-Clark, John Rodriguez, Brijender Rana, Steve Leidecker, David Hughes, Ian Park, Denise McCoy, Kerry Oakton, June Jolley, David Smaldon, Ann Brown

Population of Kent

Meradin Peachey, Denise McCoy, Declan O’Neill

Population of Eastern & Coastal Kent PCT

Andrew Scott Clark

Population of West Kent PCT

Brendan O’Connor, Val Miller

Kent Working in Partnership

Denise McCoy

Providing Effective Healthcare

Declan O’Neill

Health Inequalities

Jonathan Sexton, Deidre Bradley, Lynne Selman, Keith Wyncoll, Ann Palmer

Health of the Small Business Population

Roger Hall

Children

Jonathan Sexton, Richard Murrells

Older People

Sandro Limentani, Stephen Leidecker, Pat Huntingford, Deborah Exall, Val Miller, Malti Varshney, Dawn Newman Cooper, Debbie Smith

Smoking

Elaine Knowler, Annie Linton, Carolann Samuels, Jonathan Sexton, Julia Thomas, Mary Knowler, Sarah Kilkie, Tracey Beattie, Yvonne Philbrick

Obesity & Physical Activity

Claire Martin
<table>
<thead>
<tr>
<th>Category</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Del Herridge, Angela Painter</td>
</tr>
<tr>
<td>Drugs and Alcohol</td>
<td>Peter Gates, Roberta Wright</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>Angela Painter, John Rodriguez, Ruth Herron</td>
</tr>
<tr>
<td>Accidents</td>
<td>Steven Cochrane, Ken Muhr, Ian Proctor</td>
</tr>
<tr>
<td>The Environment</td>
<td>Caroline Davis, Kent Joint Policy Board for Housing, Tim Baker, Ben Barrett</td>
</tr>
<tr>
<td>Health Protection,</td>
<td>Jeremy Lissamore, Catherine Southwood</td>
</tr>
<tr>
<td>Communicable Disease &amp;</td>
<td></td>
</tr>
<tr>
<td>Immunisation</td>
<td></td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>Geoff Prince</td>
</tr>
</tbody>
</table>
There are several versions of this report, *the First Annual Report for Kent of the Director of Public Health 2006*. This is the *management summary version*, which comprises 56 pages.

The larger reference version of the report (c230 pages) will be made available on line at www.kentphil.nhs.uk in December 2007.

A further fuller report, containing local authority specific as well as Kent-wide and PCT-wide information, will also be made available on this website.

A Young People’s version is in development.
First published December 2007

Copyright Director of Public Health for Kent

Produced by the Joint Directorates of Public Health of West Kent PCT, Eastern and Coastal Kent PCT and Kent County Council

If you require copies or CDs of this management summary they can be acquired through the Public Health department of West Kent PCT Tel: 01622 885953.
This document is available in alternative formats.
Please call 01622 885953.