

Joint Strategic Needs Assessment for Adults in Kent

Final Version - March 2008

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1. Purpose and Introduction

A Joint Strategic Needs Assessment (JSNA) is the means by which Primary Care Trusts and Local Authorities describe the *future* health, social care and wellbeing needs of local populations and commission accordingly to meet those needs. This duty is contained in the Local Government and Public Involvement in Health Act 2007, and is part of the implementation of the White Paper, Our Health, Our Care, Our Say and the Local Government White Paper, Strong and Prosperous Communities.

This report builds upon the recently published Kent Annual Public Health Report and describes the health and wellbeing status of Adults in Kent, concentrating on projecting the data into the future. This will also include presenting the future demand based on health inequalities, the likely impact of an ageing population on health and social care and the need for preventative services to manage the demand for services. It will support the commissioning and delivery of health and wellbeing outcomes, inform subsequent stages of commissioning cycles, generally aid better decision-making and further advice on the choice of local outcomes and targets.

The recommendations of this report will shape the future investment and direction of services and will seek to define achievable improvements in health and wellbeing outcomes for Kent people, and to give existing and potential providers of services information about the scale of change.

This report looks at need, demand and supply of health and social services. Needs are defined as the variations in health status between different population groups in order to plan and commission services appropriate to those groups. Demand is defined as the patterns of service use in the population, and can show a different pattern to the needs. E.g. a deprived area may show high amounts of hypertension but the people may not be using the services there (either because they do not exist or they are inaccessible) whereas more affluent areas, although healthier overall, can be more aware of their right to quality health care and so show high levels of access to hypertension services. Supply is the term used when describing the pattern of providing care, e.g. lots of easily accessible health clinics mean there is a good supply of healthcare.

Effective joint commissioning must take into account the real needs of the population, manage the demand effectively (i.e. ensure the right people get the right services) and manage the supply (in redesigning care pathways and services to be more effectively). In redesigning pathways of care, every opportunity must be taken to target and prioritise those pathways to those in the greatest need and to ensure that these pathways are preventative.

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2. Summary of key issues

Demography of Kent

- There were around 1.37million people living in Kent in 2005 and this figure is set to grow overall by 4% in 2010 and by 11% in 2020.
- The biggest increase will be in the population aged over 65.
- From 2005 to 2020, there will be a 36% increase in the population of over 65 year olds across the whole of Kent.
- East Kent (41%) will be more affected than West Kent (30%) by the increase in older people. The areas with the greatest increases will be Thanet, Shepway and Dover.
- Although Kent is relatively affluent compared to the rest of England, it contains areas of significant disadvantage and deprivation which can easily be masked by aggregated statistics.
- Half the adult population is projected to be over the age of 50 by the early 2020s, and a large number will live in areas of relative deprivation.

Views of Kent Residents

- People want to be involved in the design and delivery of health and social services (strategically and individually), and this is a top priority for KCC and PCTs in Kent.
- In discussions about priorities, good and accessible public transport was always a high priority.
- Other priorities are being able to get good information when you need it, good housing, and better opportunities to lead more active, sociable, and cultural/spiritual lives.
- People wanted high quality services delivered efficiently - “do your job properly”. Services needed to be accessible in the broadest sense.

Health and social care needs profile in Kent

- Social inequalities contribute to some people’s poorer health in Kent.
- The average life expectancy in Kent is 79.7 and is higher in West Kent (80.2) than in Eastern and Coastal Kent PCT (79.2). The gap in life expectancy between the 20% least deprived wards in Kent compared to the 20% most deprived wards is 6.5 years. Thanet has the lowest life expectancy and Sevenoaks has the highest.
- Cancer is the main cause of death to people in Kent, followed by Coronary Heart Disease (CHD). CHD killed three times more men under 75 than women.
- Trends show that deaths from Cancer, CHD and Stroke are reducing but deaths from accidents, suicides and unintended injury are reducing at a much slower rate.

- It is important to improve the quality of data collection in primary care.
- There are four main causes of illness for Kent residents: hypertension, asthma, Coronary Heart Disease and diabetes. Hypertension accounts the largest proportion of illness.
- Mental Health services are also an increasing health concern in Kent as demand is growing year on year.
- A significant proportion of substance misusers are not in contact with services, based on extrapolation of national data.
- Demand for Social Care in Kent is likely to outstrip capacity to provide services to all who need them, making prevention and service design key issues.

Current and future demand for treatment and care in Kent

- Kent needs to prepare for significant increases in its older population.
- The main conditions affecting all patients are: Arthritis, Diabetes, chronic obstructive pulmonary disease (COPD)and Heart Failure
- The key long-term conditions affecting older people are dementia, arthritis, stroke and coronary heart disease. These are also the main causes of disability and needs for social care
- As the population ages, there will be up to 25% more people with these conditions in Kent over the next ten years
- Mental illness, learning disability and physical disability are all increasing in both incidence and complexity
- The people most affected by long term health problems and disability are more likely to live in the deprived areas of Kent.
- Improving intermediate care and preventative treatment will have a beneficial impact.
- Shaping services towards a greater emphasis on home and community care is likely to need increased joint investment which must be recouped through reduced acute and residential care.

Management of care pathways: Equity and Prevention

- More deprived areas in Kent are showing higher admissions to hospital than more affluent areas.
- Primary Care is serving the more affluent areas better.
- Data collection in primary care needs to be improved.
- However poorer areas are managing care pathways appropriately, with generally fewer unplanned admissions for chronic conditions.
- Prevention in poorer areas of Kent can be improved by prioritising and targeting.
- Improving care pathways using technology for home care services will help older people in poorer areas and improve access to health care.

- Prevention of Coronary Heart Disease, Stroke, Diabetes and Musculoskeletal problems (which includes arthritis) is a priority for the older population, particularly in deprived areas.
- Focusing on mental well being, reducing obesity and smoking prevalence in deprived communities will have an impact in reducing health inequalities and creating more efficient services in Kent.
- Working with carers, community services and wider partnerships will improve the health and well being of older people and increase the capacity of communities to support people in need of social care.

3. Recommendations

Commissioning Improved Care Pathways

The Joint Strategic Needs Assessment needs to inform commissioning decisions and change service delivery responsively in light of the changing needs of the population. As such the following recommendations are made:

1. Care Pathways will need significant shaping for services to cater for increasing older people. The care pathways will need to be wide in scope, preventative and joined up between health and social care. Prioritise Coronary Heart Disease and stroke care pathways for redesign, followed by Dementia, Chronic Obstructive Pulmonary Disease and Musculoskeletal conditions.
2. Demand Management work streams need to focus on equitable distribution of care pathways for those more deprived local authorities. Instigate an Equity Audit Process.
3. Where there are recommendations from existing needs assessments: e.g. Diabetes, Substance Misuse etc, collate them and ensure they are implemented.
4. Better targeted and equitable health promotion and prevention is needed. Each care pathway should end in a prevention and promotion programme or approach, e.g. Coronary Heart Disease – Stop Smoking. The priority Choosing Health areas for Older People are: Smoking, Obesity, Alcohol, Mental Health and Falls Prevention. Better access to promotion and prevention resources are needed both for older people and for younger adults with disabilities and complex needs. A directory/resource and training for front line staff and carers as well as an on-line resource for ease of access (e.g. in libraries and Gateways) for the public is needed. This should be delivered alongside community development and a media campaign.

5. Understanding where commissioning takes place is vital and having a clear understanding for all partners of the various timescales for local commissioning plans is needed. A joint commissioning forum for the PCTs, KCC and other involved partners is to be established.
6. Carers issues and views will need to form part of the needs assessments and commissioning, including qualitative assessments regarding those with disabilities with ageing carers.

On-Going Joint Needs Assessment

The Joint Strategic Needs Assessment is designed to be iterative and as such the following recommendations are made:

7. Conduct in-depth qualitative needs assessment for people with learning disabilities and physical disabilities to create a fuller picture of their health needs.
8. Conduct a full needs assessment on mental health services, starting with community mental health services. This work will be jointly commissioned by Laretta Kavanagh, the Director of Commissioning for Adult Mental Health Services (based at Medway PCT which is the lead PCT for Mental Health on behalf of the other two Kent PCTs), Meradin Peachey, the Director of Public Health, and Steve Leidecker, the Director of Operations for KASS.
9. Conduct an alcohol needs assessment which delivers a Kent Wide Alcohol Strategy that can be broken down by district council.
10. Liaise with the Kent Housing Group and the Joint Policy and Planning Board (housing) to ensure housing issues are fully integrated into future JSNA work.

Data

One of the key drivers of the Joint Strategic Needs Assessment is better joined up commissioning and as such better use of joined data-sets is needed. Improvements to current data-sets and analysis which enables people to understand the key policy implications are required. A new Kent Public Health Observatory function is being created and many of the following recommendations will be taken forward by the Kent Public Health Observatory, working with KCC's Analysis and Information Team.

11. The data-set used in the Joint Strategic Needs Assessment should be used to guide commissioning at both county and local level, and the finally

agreed data-set (incorporating information about benefits, housing needs survey, and other such relevant information) should be a standard input to commissioning plans for both county and localities, both at District/Borough level and where possible and relevant, at ward and SOA ward level. A key aim will be to enable County, District and Parish Councillors to understand the key health and wellbeing issues pertaining to their constituency.

12. Further modelling of social care and health service data is needed involving local people and clinicians starting with Chronic Obstructive Pulmonary Disease, stroke and dementia.
13. A finer grained analysis of health inequalities will be needed to target pathways and interventions and a list of key levers as a result of this analysis will be produced.
14. QMAS Data-sets (collected by GPs) need to be interrogated and improved, particularly in West Kent and specially trained PRIMUS facilitators will improve practice data sets and it's applicability for commissioning.
15. A core data and analysis group should continue, and be widened to involve other partners.

4. Overview of the Demography of Kent

This section is a short overview of the demographics of Kent. It summarises the Director of Public Health's Annual Health Report for 2006.

4.1 Resident Population Estimates

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. In Kent, 17% of people are aged over 65, marginally higher in Eastern and Coastal Kent PCT (18%) compared to (16%) in West Kent. At present the largest proportions of people resident in the county are aged between 35-44 and 55-59. In Kent, there are lower proportions of younger people and higher proportions of older people than in England and Wales on average (Table1).

Table 1. Mid 2005 Resident Population Estimates.

<i>Resident area</i>	<i>2005 Estimate</i>		
	Number of Residents All Ages	Number of Residents 65+	% Residents 65+
Eastern and Coastal Kent PCT	714,200	131,400	18.4
West Kent PCT	655,700	105,700	16.1
Kent County Area	1,369,900	237,200	17.3
England and Wales	53,728.8	8,228.4	15.3

(Source: Office of National Statistics)

4.2 Population Projections: An Ageing Population

Projections from the Office of National Statistics predict dramatic increases in the elderly population over the next 15 years. By 2026 and compared to England as whole, Kent will have smaller (but nonetheless significant) rises in its population of over 85 year olds, but will see a slightly bigger rise in its 65-84 year olds than the national average. Overall, the population in Kent is growing at a slightly slower rate than the England average but is ageing (Figure 1).

In Kent County the all-age population is set to increase by 4% by 2010 and 11% by 2020 (Figure 2). There are bigger expected increases in the over 65 population of this area, 9% by 2010 and a massive 36% by 2020 (Figure 3). The highest proportions of elderly people reside in Thanet, Shepway and Dover Local Authorities. By 2020, 21% of the population of Kent will be aged over 65, many of whom will be living in areas of economic and social deprivation.

As older people live longer it is likely they will need more care and support. This places a considerable challenge for local services to provide high quality care for an informed population with high expectations.

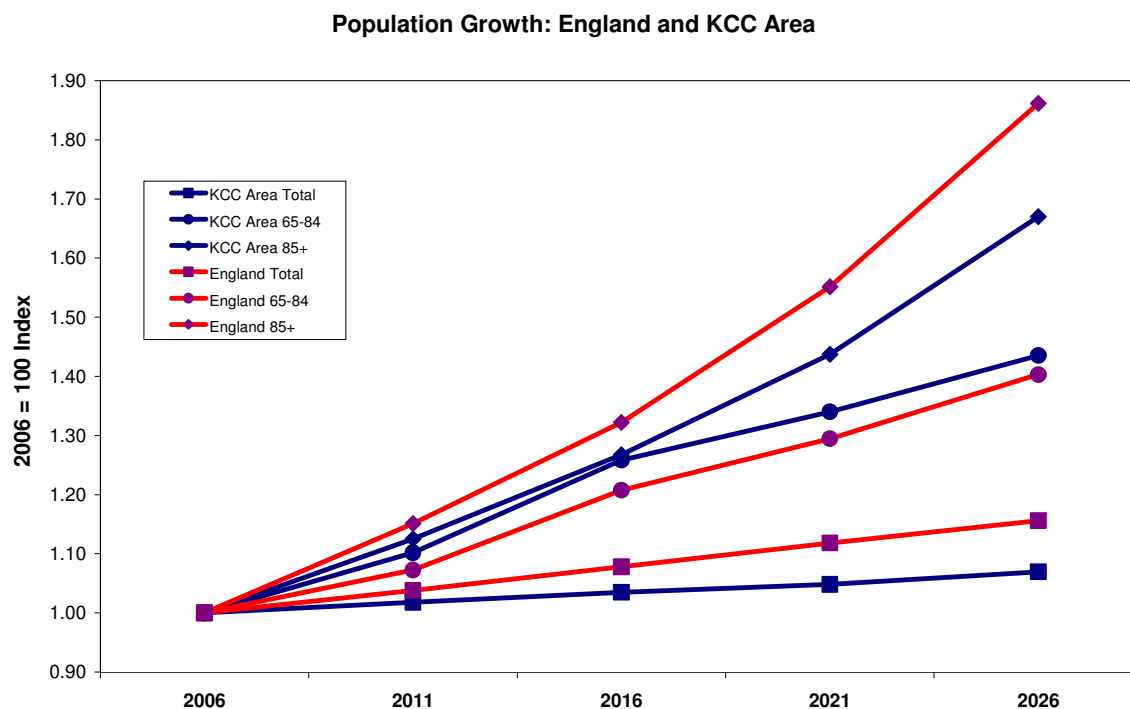
4.2.1 West Kent

The population of West Kent PCT is predicted to increase by 47,900 (7.3%) in the next 15 years (2006 – 2021). This growth rate is lower than the average for Kent & Medway but higher than the national average (6.7%). Like Kent as a whole, the older population will experience the greatest increase. In West Kent PCT the greatest increase will be in those aged 65+ (30%) which amounts to around 18,600 more people in that age band by 2021.

4.2.1 East Kent

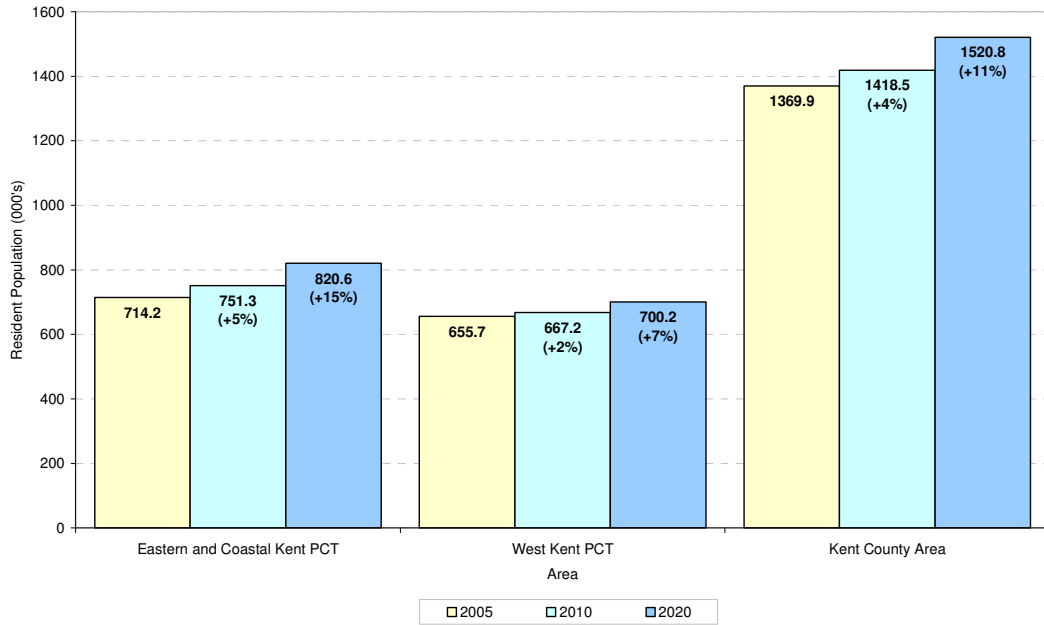
The picture is similar in East Kent and Coastal PCT. The Office of National Statistics predicts a dramatic increase in the population over the next 15 years with the biggest increase in the over 65 years of age. In Eastern and Coastal Kent PCT the all-age population is predicted to increase by 37,100 (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. These are greater than the increases expected for the County as a whole and the particularly relate to increases in the proportions of elderly persons living in the Thanet, Shepway and Dover Las

Figure 1



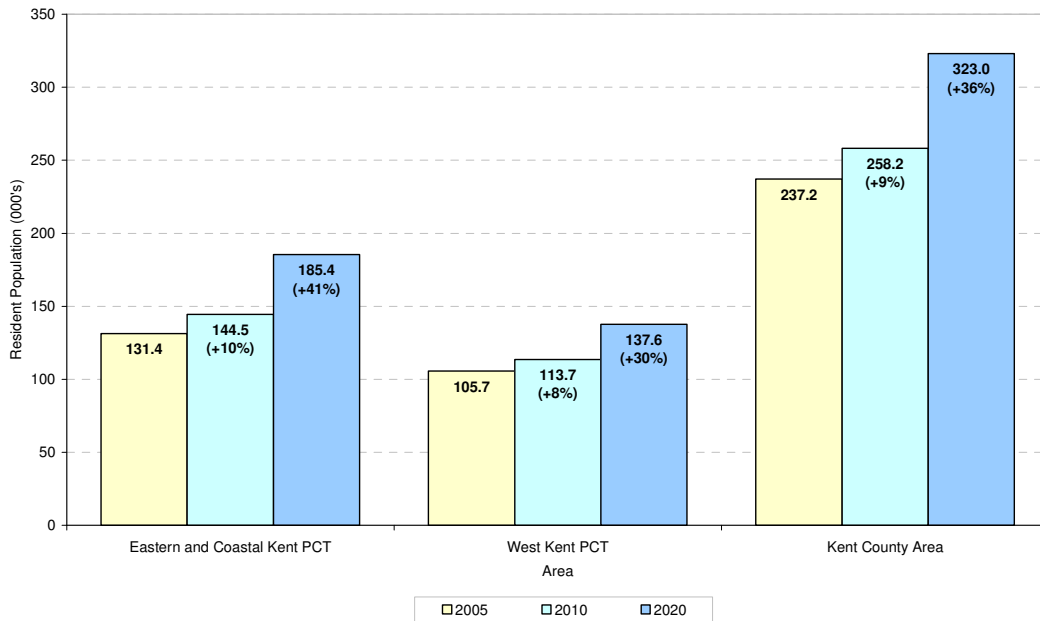
Sources: England: 2006 based National Projections (GAD)
 KCC Area: Strategy based Forecast (September 2007) Kent County Council

Figure 2. Population Projections to 2010 and 2020 for Residents All Ages, Showing Percentage Change from 2005.



Source: KCC, 2007

Figure 3. Population Projections to 2010 and 2020 for Residents Aged 65+, Showing Percentage Change from 2005.

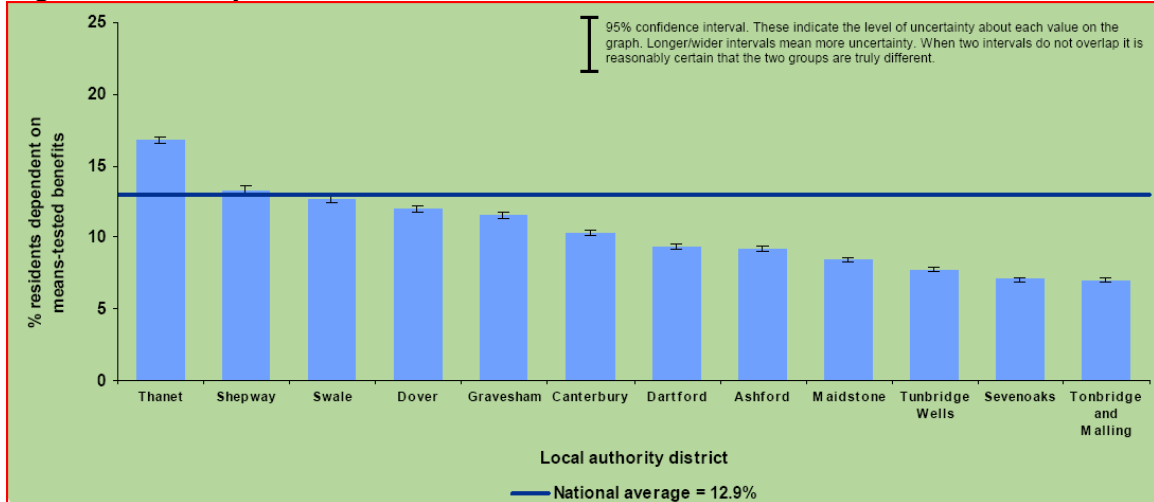


Source: KCC, 2007

4.3 Deprivation

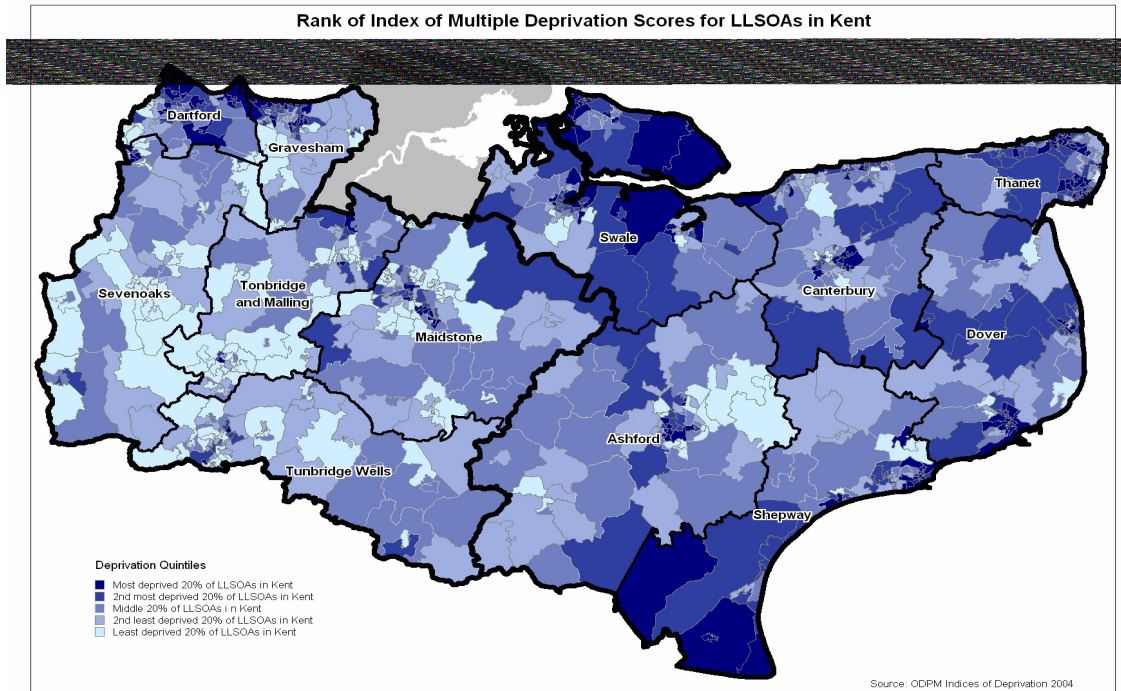
Kent County is less economically deprived than England as a whole, and this forms part of the relative affluence found in the South East of England (Figure 4). Eastern Kent scores higher on a number of indices of deprivation, such as child poverty than West Kent PCT and England as a whole. However both West and East Kent have areas of considerable deprivation. These are often small pockets of deprivation 'hidden' within the more affluent areas and only unmasked by fine grained analysis of data e.g. at super output area or wards (Figure 5).

Fig 4 Income Deprivation in Kent CC.



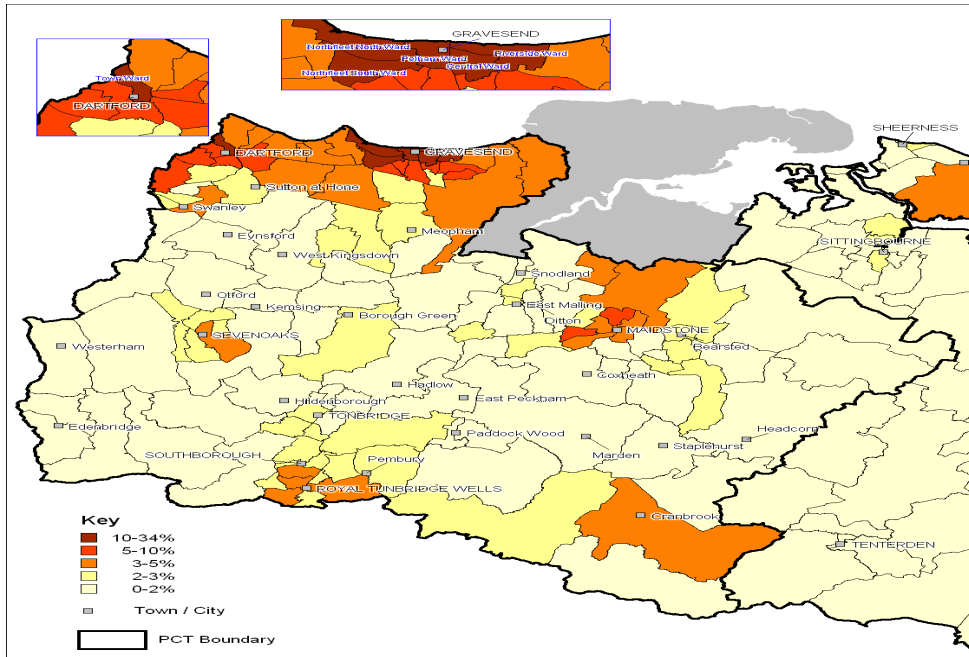
Source: Community Health Profiles 2006.

Figure 5.



4.4 Ethnicity. 96% of the Kent population is white. Figs 6 and 7 show the distribution of Black and Ethnic Minority Groups in the West Kent and Eastern & Coastal Kent PCTs. Figure 6

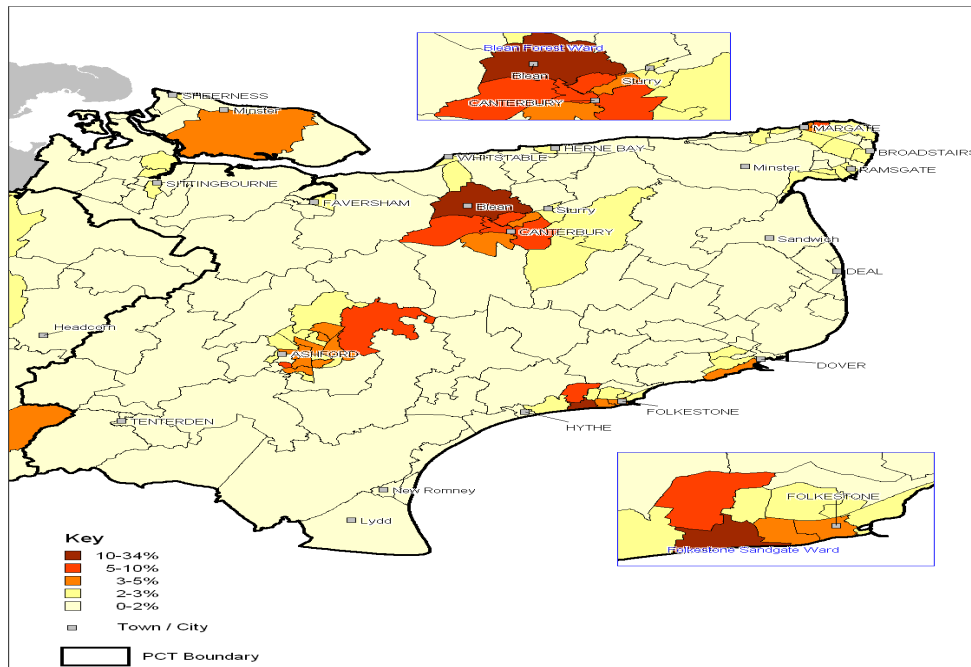
Population in Black or Ethnic Minority Groups in West Kent PCT Electoral Wards, 2001



Source: Census 2001, Table KS06

Figure 7

Population in Black or Ethnic Minority Groups in Eastern & Coastal Kent PCT Electoral Wards, 2001



Source: Census 2001, Table KS06

5. Views from Kent Residents about their Health and Care

5.1 Involving People

There has been extensive consultation with people about the future of health and social care services in Kent, due in part to nationally-led changes and local restructuring of Health Services, and because of the refresh of 'Active Lives', the ten year vision for social care in Kent.

Strong messages emerged about the importance of listening to and involving people, treating people with dignity and respect, supporting independent living, providing health care close to (or in) people's homes, and ensuring people did have choice and control over the support they received. Prevention, and health promotion was a key theme, although people also wanted good quality services for those needing more intensive support. The Active Lives consultation revealed particularly strong support for services for carers, and for advocacy.

5.2 Health Promotion and Well Being

In the last few months there have been discussions with the general public about what should be included in Kent's older people's strategy. In these discussions, people gave particular priority to health promotion and opportunities to increase healthy living (e.g. subsidised sports activities such as swimming) and promote good mental health (e.g. social activities and networks). Transport was a key issue, and closely linked to concerns about the location of services (people were worried about how to get to services if they were reliant upon public transport). The quality of housing, and the importance of ensuring its suitability (warm, secure, safe, accessible) was another theme.

5.3 Accessible Services

The importance of easily accessible, timely, relevant information keeps being highlighted by people as a critical issue. People felt that it was vital for GP surgeries, and other forms of primary care, to be excellent at sign-posting people to where they could get further information about and support for their condition. Not everyone understood the extensive role that libraries have in information provision. The importance of providing information in different ways, from different sources, for different 'communities of need', was emphasised.

5.4 "Do the job properly"

The public also put great emphasis on quality issues -"do the job properly". For example, staff should turn up at the time they said and do what was expected of them. People in hospitals or care homes should be kept clean, should have good nutrition (and be helped to eat if necessary), and be kept well hydrated. In looking ahead to developing services, we must not forget the importance of getting the basics right now.

6. Overview: Health and Social Care Needs of Adults in Kent.

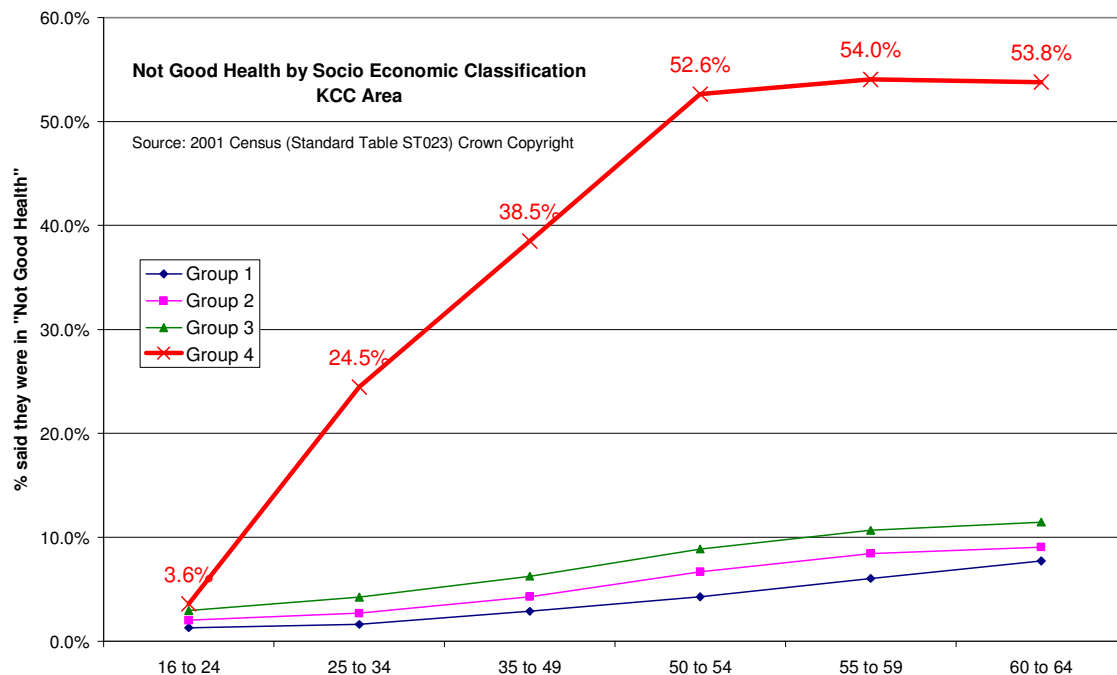
The following section presents an overview of the health and social care needs of the population of Kent. Far more detailed information is available in the Kent Annual Public Health Report 2006 and it is not intended to repeat information contained in that document. This section will concentrate on the main causes of mortality and morbidity for adults in Kent, particularly highlighting conditions that impact on an ageing population.

6.1 Health Inequalities

In the UK, poorer paid people suffer more chronic sickness than other income groups over a range of illnesses and conditions, particularly musculoskeletal and respiratory ones. There are a range of complex and interacting causes to these health inequalities, including: poorer access to health and social services; poorer lifestyle choices; living in worse social conditions; living in more stressful situations and environments; having less choice over living and working conditions; and poverty of aspiration and self esteem.¹

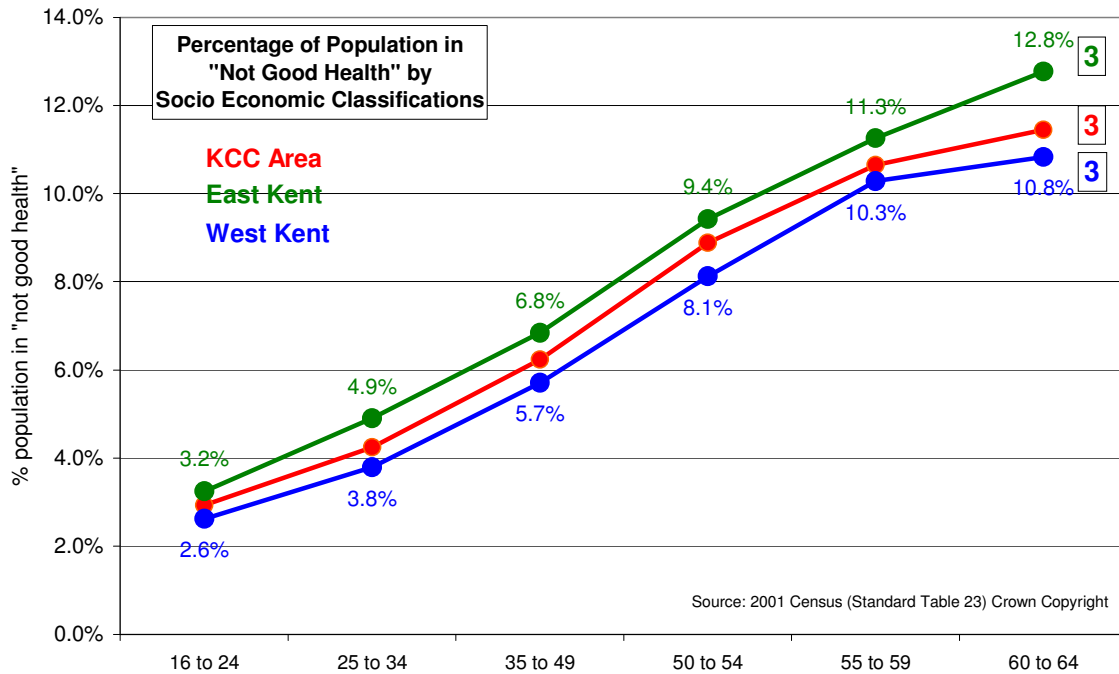
The gap between those in the highest social classes (Group 1) and the lowest social class (Group 4) gets wider as people get older. The sharpest rise in reported poor health is between 16-34 which highlights the need to focus on prevention at earlier ages (fig 8). In Kent, people in East Kent report more poor health than in West Kent for all ages (fig 9).

Figure 8



¹ Marmot, M. Social determinants of Health Inequalities. Lancet. 365: 1099-104

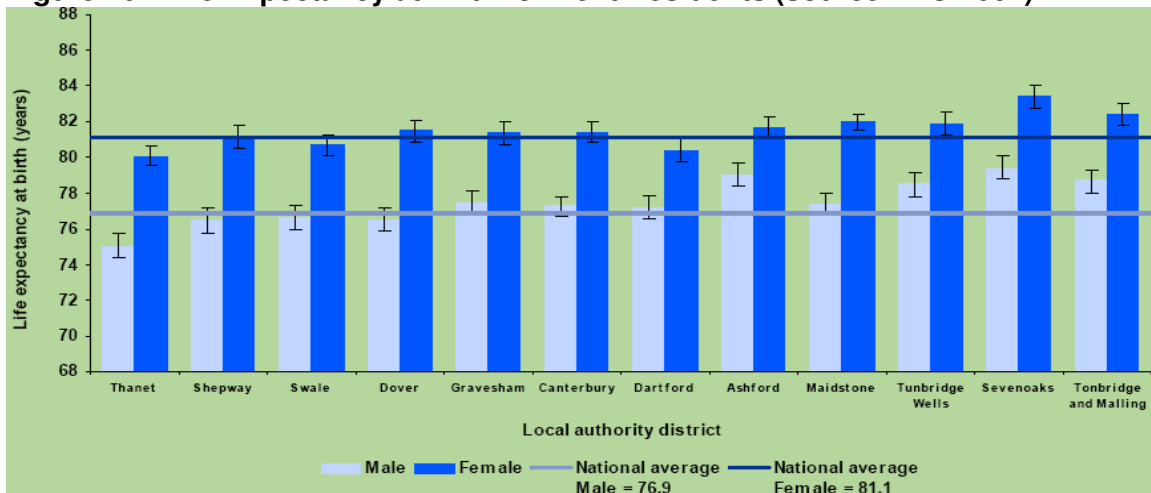
Figure 9



Life Expectancy

The term 'life expectancy at birth' refers to 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 used as a measure of overall quality of life in an area. The difference in life expectancy between areas is used as a measure of inequality and is believed to have a detrimental social effect on the overall area. In West Kent PCT, the average life expectancy is 80.2 years old, higher than that of Eastern and Coastal Kent PCT (79.2). Although life expectancy is higher in all local areas than the national average, the difference in life expectancy between the 20% least deprived wards in Kent compared to the 20% most deprived wards is 6.5 years. Thanet has the lowest life expectancy and Sevenoaks the highest (fig 10). More marked differences exist in mortality for people with specific diseases.

Figure 10: Life Expectancy at Birth for Kent Residents (source LHO 2007)



6.2 Causes of Death and Illness

Historically, diseases caused by infections and accidents accounted for the major causes of death and illness in society. As public health has improved and the population lives longer, it is vascular disease, cancers and other long term conditions (e.g. musculo-skeletal conditions) that have overtaken as the major killers and causes of overall ill health.

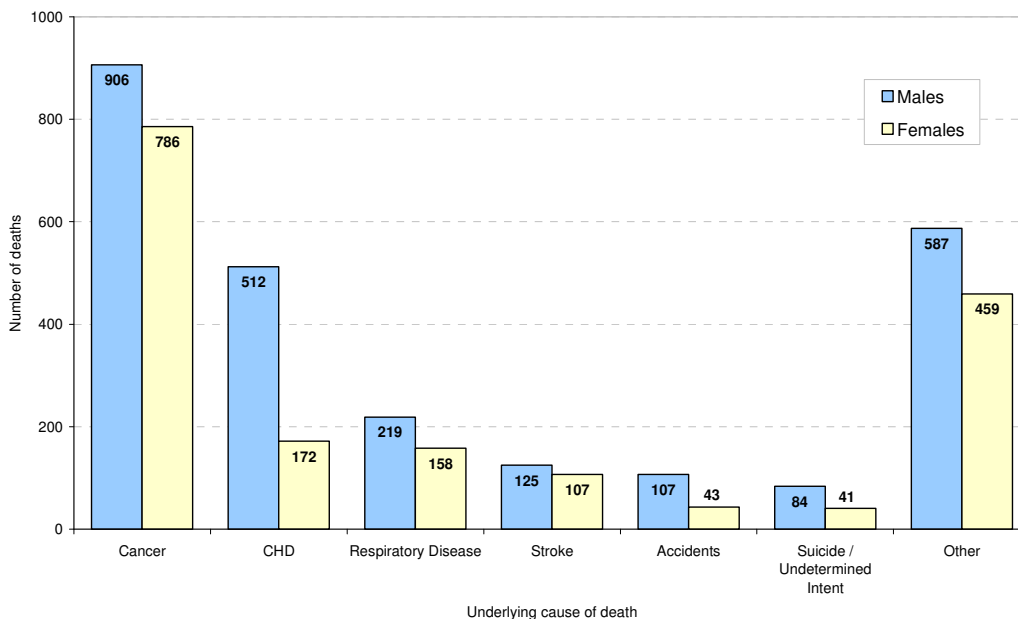
6.2.1 Main Causes of Mortality in Kent: Vascular Disease & Cancer

Cancer is the biggest single cause of death in residents of Kent County, both in the under 75 age group and all ages, followed by Coronary Heart Disease and respiratory diseases. Cancer killed just over 900 males and nearly 800 females aged under 75 in Kent, with around another 950 deaths for each gender over the age of 75.

In Kent, although numbers of people dying from CHD were roughly evenly split between the sexes, under the age of 75 (premature death) CHD killed almost three times as many males (512) than females (172). There is a higher incidence of CHD in males under the age of 75. Together, CHD and stroke accounted for 916 (21%) premature deaths (under 75), and 3846 (28%) deaths of people from all ages.

Cancer and circulatory disease mortality trends are decreasing steadily since 1997 and if this trend were to continue the county will reach the target reductions of 20% and 40% respectively by the year 2010.

Figure 11. Numbers of Deaths by Cause 2005. Kent County Residents Aged Under 75.



Rates of accident mortality and deaths from suicide and undetermined intent have remained fairly stable since 1998, with only a very slight downward trend. Extrapolations from the progress made so far show that larger reductions in deaths from these causes are required in order to reach target in the time given. From the 2005 figures, mortality

rates for accidents must be reduced by a further 12.8%, rates for suicide and undetermined intent by 22.7%.²

6.2.2 Main Cause of Illness in Kent (Morbidity)

The QMAS dataset is used by primary care and incentivises both certain treatments and collection of key health data. There is a need for caution in reviewing the QMAS data from primary care. As this is a relatively new dataset, there may be patients that have a condition but have not yet been counted by their practice, not registered with a practice or not yet diagnosed. Another important issue may be that people in more affluent areas are better at consulting GPs about their health than poor people so the data can say more about how people access services than the relative prevalence of conditions in Kent. Therefore it is likely that the below prevalence figures are not be completely accurate. However the QMAS database is an evolving one and it is expected at over the time will become more complete.

The main causes of illness in Kent (both East and West) are: hypertension, asthma, diabetes and CHD (Table 2). The prevalence of these conditions is slightly higher in Eastern and Coastal Kent than in West Kent, but only slightly. By far the most common of these conditions treated at primary care is hypertension. In Kent 12.3% of the population (counted by primary care) suffer from hypertension, which is around the average for England and Wales. Eastern and Coastal Kent's patients have a prevalence of around 13% and West Kent's prevalence is just 11.8%, roughly in line with the England and Wales average. Mental Illness is also a key issue and cause of admission in Kent (see Section 7).

Table 2

Main Causes of Illness at Primary Care in Kent.	West Kent	East Kent	Kent & Medway	England & Wales
Hypertension	11.8%	12.8%	12.3%	12%
Asthma	5.6%	5.3%	5.4%	5.8%
Diabetes	3.4%	3.7%	3.5%	3.8%
Coronary Heart Disease	3.2%	3.6%	3.3%	3.7%
Hyperthyroidism	2.6%	2.6%	2.6%	2.4%
Stroke and Transient Ischaemic Attack	1.6%	1.6%	1.6%	1.5%
Chronic Obstructive Pulmonary Disease	1.4%	1.3%	1.4%	1.4%

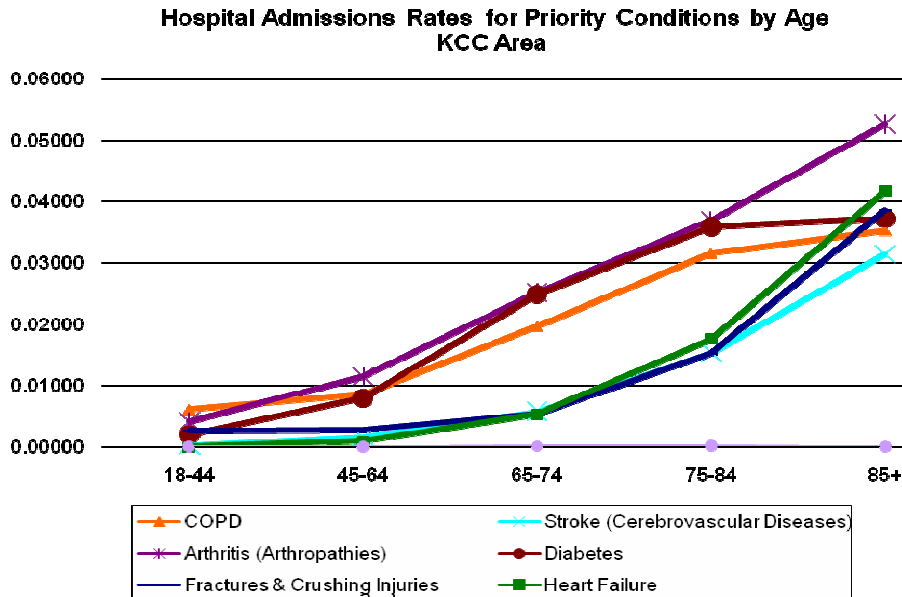
Source: QMAS: 2006

Recording of hypertension is higher in Thanet, Shepway, Sevenoaks and Dover than the Kent average. There is a higher than Kent average Asthma prevalence recorded by QMAS in Sevenoaks, Tonbridge, Tunbridge Wells and Ashford. This may reflect some underreporting from practices in the more deprived Local Authorities. Diabetes prevalence recorded in Kent from QMAS is higher in Thanet, Shepway, Swale and Dover. Gravesham has the highest prevalence in West Kent.

² For more details see the Annual Public Health Report for Kent 2006

CHD prevalence in primary care is higher in East Kent and Coastal PCT, the highest rates seen in Thanet, Shepway, Dover and Canterbury. Again, the lower rates seen in the relatively deprived Local Authorities such as Gravesham and Dartford may reflect problems with the data and will need to be looked at in relation to hospital admission data for CHD and heart failure to understand more fully.

Figure 12



Hospital activity refers to the rate of admissions to Hospital and is a proxy measure for incidence and severity of disease because a patient with a long term condition should only need a hospital admission if they are unable to manage the condition at home or with help of a primary care physician (i.e. if the condition has deteriorated/ become acute). Typically conditions occur more the older a person becomes and often people can have more than one condition. Priority conditions should be those that see a large increase as people get older due to the fact that many of these conditions occur together with age, will have greater incidence as the population ages and in many cases the severity can be prevented at earlier ages (Figure 12). These conditions affecting Kent patients aged 45-65 are: Arthritis, diabetes, COPD and can accelerate if not managed appropriately. Heart Failure, Fractures and Crushing injuries and Stroke are conditions that will accelerate in people over 65, and given the ageing Kent population, the management of these conditions should also be a priority. Although the patterns for these conditions is similar across East and West Kent, East Kent shows a slightly higher admission rate for these major conditions for people over 45 years old.

6.3 Substance Misuse in Kent

A Substance Misuse needs assessment was undertaken in February 2007 and the Treatment Plan 2007/08 has addressed some of the recommendations. In December 07, data was refreshed to identify issues relating to met and unmet needs in Kent. Although there are some problems with data that means not all gaps can be identified with a definite level of accuracy, the key issues to be addressed in 2008-9 have been set out

by the Kent Drug and Alcohol Team and further work is underway to shape commissioning over the longer-term.

6.4 Social Care Needs

Some people with long-term illnesses or conditions (including people with learning disabilities or mental health problems), and frail older people will need social care. The next section deals with future projections for social care demand. Whereas health care is a universal service, state social care is means tested and also only available to people whose level of need meets the eligibility criteria, although advice and information is provided for all.

National evidence of the rates of various kinds of impairment (eg visual, hearing, learning disability, and long-term health conditions) would suggest some 112,000 people in Kent have a significant degree of impairment, although it is impossible to establish accurate information on this. Figures applied from national statistics may not reflect the population profile of this area. The estimates are not age adjusted so in some cases, where impairments are more frequent in older people, the numbers suggested for Kent are likely to be underestimated as Kent has a higher proportion of older people over pensionable age compared with England and Wales as a whole. Another reason for the difficulty in producing acceptable figures is because of the different definitions, classifications and levels of disability. Also some people will have more than one disability.

Currently, Kent County Council provides support to some 30,000 people to live at home, and some 8,000 people to live in residential or nursing care. Two thirds of places in residential and nursing care in Kent are filled by people who are not supported by KCC (so are either funding themselves, or placed by other authorities from outside Kent). In the next section, future social care demand is extrapolated from current trends.

6.5 Carers and caring by older people

Much social care is provided formally and informally by the community and voluntary sectors and, of course, the bulk of caring is provided by relatives and friends. An estimated 16% of the national population are carers, one in five households contains a carer, and over a third of people will become carers post-retirement. It is important thus to note that older people are not just consumers of health and social services, but also major providers of care. Across the South East, 11.7 per cent of those aged 65 and over responded in the 2001 Census that they provided unpaid care to others because of long-term physical or mental ill-health or disability, or problems related to old age. Many of those providing care are themselves in poor health. There are 22,000 older people across the South East (equivalent to 15.1 per cent of all those aged 65 and over providing unpaid care) who reported their health status as 'not good' in the 2001 Census but were still providing care to others. Research into the position in Kent has been done by the Centre for Health Service Studies "Who Cares in Kent" and KCC has also recently published a Select Committee report on Carers in Kent and is committed to implementing its recommendations.

7. Current and Future Demand for Treatment, Care and Support

The most salient issue affecting the adult population in Kent is that of its ageing. More information on the wider range of issues facing the working age population, such as sexual health, emotional health, drugs and alcohol are to be found in the Kent Annual Public Health Report 2006 and subsequent iterations of the Joint Strategic Needs Assessments (see the recommendations for the next phases of work).

This section describes the current demand for services indicated by hospital admission rates and access to social care services and will then project this demand into the future based on the current knowledge of how the population will change. This information is available broken down to District level.

7.1 Current Demands for Health Care

Currently, the main conditions affecting patients in Kent are: Arthritis, Diabetes, Chronic Obstructive Pulmonary Disease (COPD) and Heart Failure and as people get older they are more likely to have these conditions, and therefore more likely to be admitted to hospital (fig 13).

Health Services are often the main point of contact when a person needs social support or treatment, particularly as a person gets older. When a person's care needs become more complex, social services are also involved. The main conditions that lead people to need social care and support (particularly at older ages) are the range of musculoskeletal (MSK) conditions (such as arthritis, fractures and pelvic injuries); neurological conditions (such as dementia and Parkinson's disease) and complex conditions such as severe learning disabilities.

For the age group of 18-44, Thanet has the highest rate of hospital admissions. However, the rest of the admission rates for the localities do not follow in order of deprivation as the relatively affluent Tunbridge Wells and Ashford follow after Thanet with the next highest hospital admissions.

East Kent as a whole has more hospital admissions than West Kent (as expected) but Tonbridge & Malling and Sevenoaks have higher admissions than people from the more relatively deprived Dartford and Gravesham. Prevalence of long term conditions tends to correlate with deprivation, so it is interesting to note that this pattern is not seen for 18-44 year olds in Kent for Hospital Admissions. COPD appears to be a large contributing factor to the differences in hospital admission rates.

The inequalities in health between East and West Kent really begin to show themselves at the ages of 45-64 with a relatively large gap in the rate of hospital admissions between the two PCTs. Interestingly, within the PCTs the admission rates do not follow the pattern of deprivation (apart from Thanet). The Eastern Coastal towns show higher admissions for back pain and other musculoskeletal (MSK) conditions than West Kent.

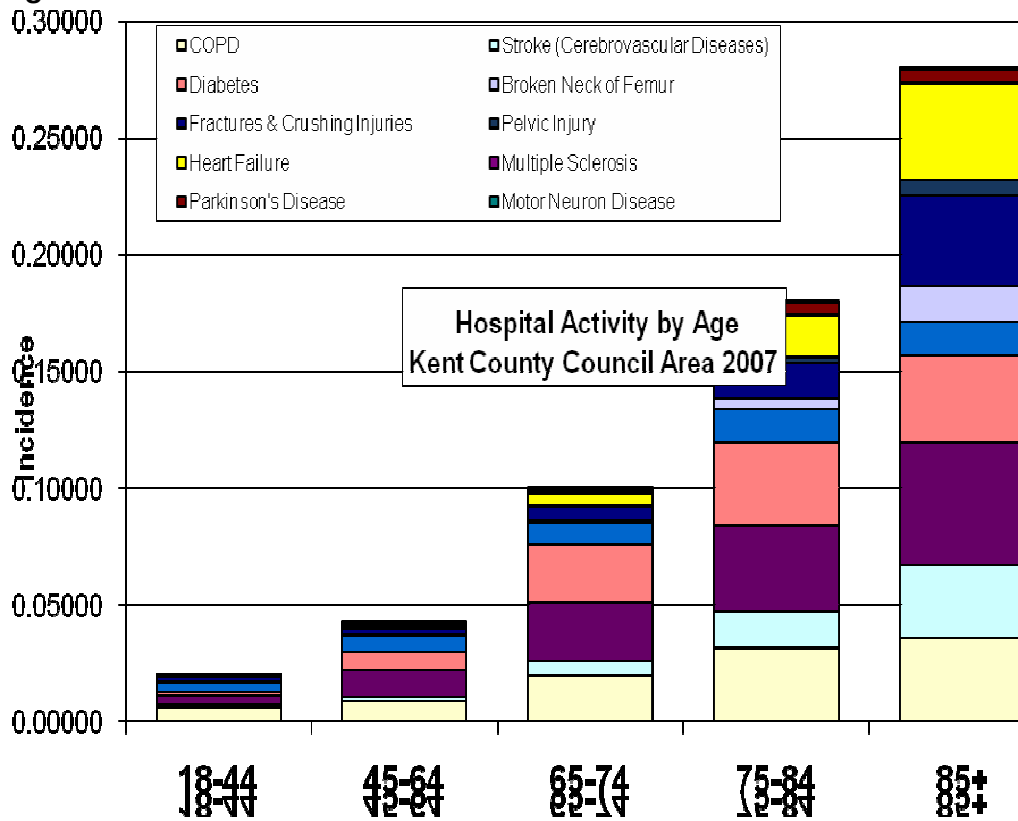
At the ages of 65-75, Thanet is still the highest local authority for admissions to hospital. Tunbridge Wells and Tonbridge & Malling are also higher than other more deprived parts

of East and West Kent. This may reflect the ages of their population. For people aged between 74-84, there are still many more admissions from Tunbridge Wells and Tonbridge & Malling. Many of these admissions are caused by COPD and MSK conditions.

Dartford and Gravesham, have fewer MSK conditions but are comparable to the rest of Kent for Heart Failure admissions. This is notable given Dartford's low indicated QOF prevalence (see section 5 above) and indicate that improvements in the preventative pathways for COPD, MSK and Coronary Heart Disease (particularly for Dartford and Thanet) are necessary.

Over the ages of 85, vascular disease, heart failure, arthritis and stroke dominate. Again, Thanet's population are at high risk of admissions. Improving the health of people in Thanet would bring the average admission rates down for the whole of Kent. Targeting Dartford, would also improve health inequalities in West Kent and contribute to reducing inequalities in Kent overall.

Figure 13



7.2 Future Demands for Health Care

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

The key long-term conditions that affect older people over 65 are dementia, arthritis, stroke and coronary heart disease. These are also the main causes of disability and need for social care. As the population ages, there will be up to 25% more people with these conditions Kent over the next ten years (figs 14, 15 and 16).

There are four conditions that will dominate the demand for health care in the next 3-5 years, and these are arthritis, COPD, diabetes and heart failure (along with stroke and other vascular diseases). These conditions account for around 90% of all hospital admissions in Kent across all ages. The biggest increases admissions in the next 3-5 years is predicted to be for Heart Failure and Stroke (combined) and if current trends continue there will be a predicted rise of almost 7% in these vascular conditions. This is a fairly significant increase given that these conditions are largely preventable. The other conditions show increases of around 3-4%. Clearly improving the preventative care pathways for these four conditions is a priority for Kent, particularly focusing on adults aged 45-64. All these conditions are highly sensitive to reductions in smoking behaviour, healthy eating and increased physical activity and make smoking and obesity key public health priorities for both PCTs and KCC.

Figure 14

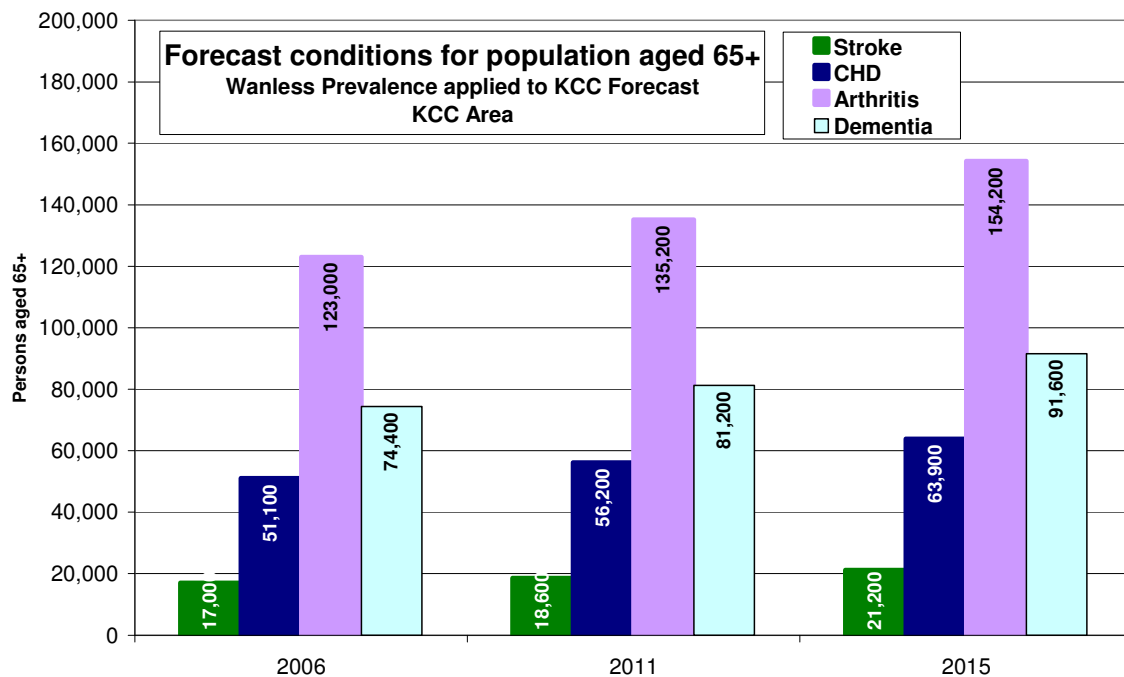


Figure 15

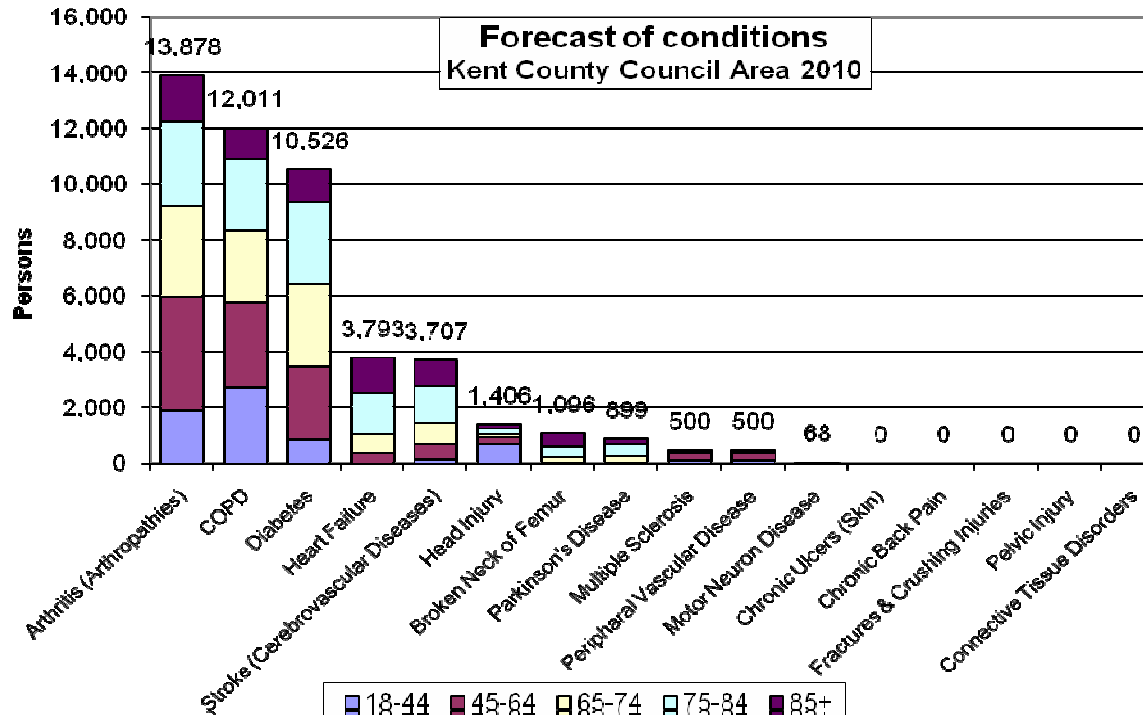
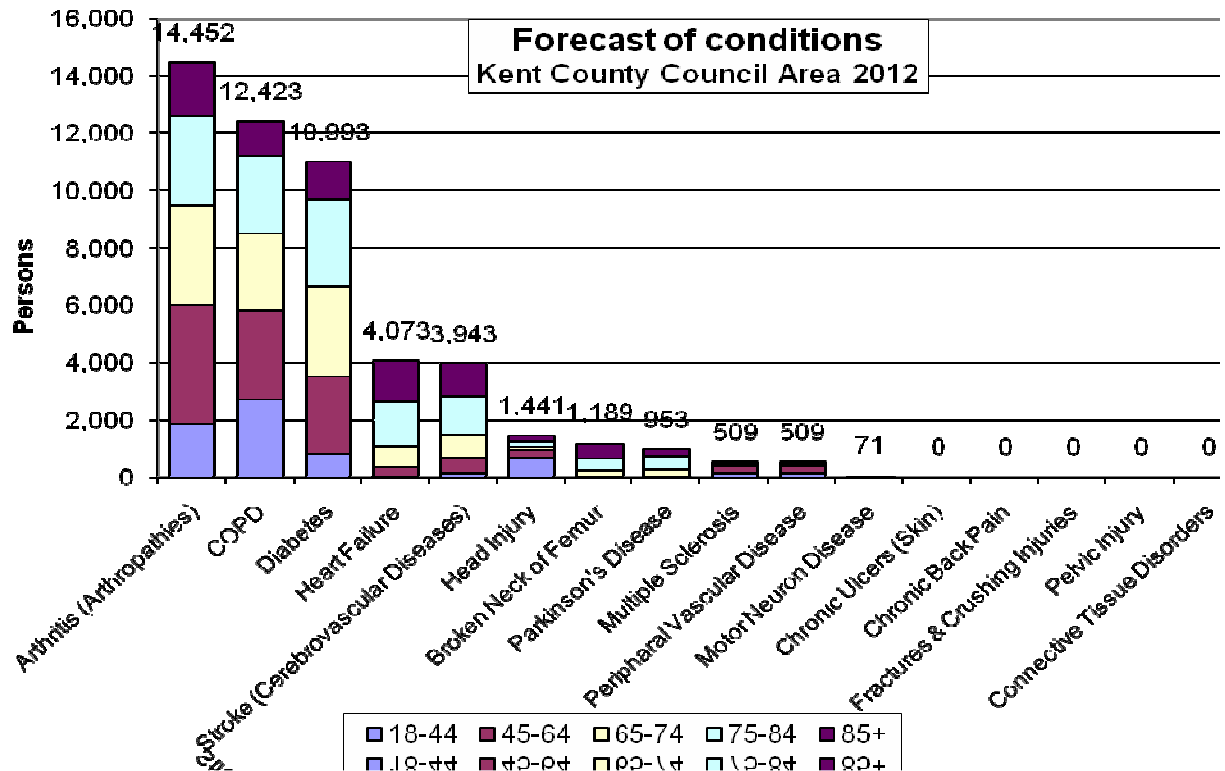


Figure 16



7.3 Current Social Care Demand in Kent:

7.3.1 Eligibility criteria

Social Services nationally are provided on the basis of an individual needs assessment in order to assess what level of risks an individual faces regarding their ability to live and cope independently. There are nationally-set eligibility criteria, and Kent is unusual in providing services to people with only *moderate* levels of need, whereas over 75% of authorities now only provide services to people whose needs are *substantial* or *critical*, because of the limits on their resources. KCC has retained the moderate level of eligibility criteria because of the importance of early intervention and support to prevent people's conditions from deteriorating. Assessments must be made based on the person's present and future needs, severity of their condition and the resources available. Regardless of whether people are eligible for services, it is important that they have excellent advice and information about available support, and help in deciding how to spend their own money. This requires the voluntary agencies, carers and community and statutory services to work closely together. Active Lives, Kent's 10 year vision for social care, sets out a framework for making this happen.

7.3.2 Direct Payments and Individual Budgets

Direct payments are cash payments made to individuals who have been assessed as needing services, in lieu of social service provisions. They can be made to disabled people aged 16 or over, to people with parental responsibility for disabled children, and to carers aged 16 or over in respect of carer services. A person must be able to consent to have a direct payment and have the capacity to manage one, although they can have assistance to manage their payment on a day-to-day basis. The aim of a direct payment is to give more flexibility in how services are provided. By giving individuals money in lieu of social care services, people have greater choice and control over their lives, and are able to make their own decisions about how their care is delivered. The choice and control offered by direct payments is likely to increase the number of people accepting social services help, and already there is evidence that they are enabling previously unmet need to be addressed as a quarter of Kent people on Direct Payments in 2007 were previously unknown to Kent Adult Social Services.

Government policy, supported by KCC, is to continue to increase the proportion of people on Direct Payments, and to move towards having Individual Budgets which incorporate other funding streams, not just social care, and indeed the Government has made a commitment to include Health funding within Individual Budgets in the future.

Direct Payments and Individual Budgets are transforming the shape of social care in Kent. They enable people to use resources to tailor support to their own unique needs, rather than selecting an existing service. This does mean, though, that it is very difficult to plan for the future because commissioning decisions will increasingly be made by many individuals rather than via strategic contracts. Over the next five years assumptions have been made about the level of increase of Direct Payments, based on the rapid level of increase over the last three years.

7.3.3 Demand for Services

In terms of numbers of people, it is Older People’s services that have the most clients. Unless a person is able to pay for their own care or has a supportive family, many people will find their way to social services at some point as they get older, particularly in the more deprived areas of Kent e.g. East Kent has higher numbers of older people in social services than West Kent. However, Social Services also supports younger people with complex and expensive needs, such as people with profound learning disabilities and severe physical support needs. Joined up services with hospital, primary care and community services are critical.

7.3.4 Promoting Independence, Care and Support Closer to Home

A key aim of any preventative approach to join up health and social services is to enable people to live as independently as possible in their own homes. This aim translates to shifting services from hospital, residential and nursing homes into more domiciliary and community based settings. Currently 17% (just fewer than 3000 people) of all older people known to social services are in nursing and residential care across Kent with the rest getting care and support at home and receiving direct payments to arrange their own support (fig 17). 30% of people with a learning disability known to KASS are in nursing and residential care (1,200 people, fig 18). A much smaller proportion of people known to social services with a physical disability are in residential and nursing care (Fig 19).

Figure 17

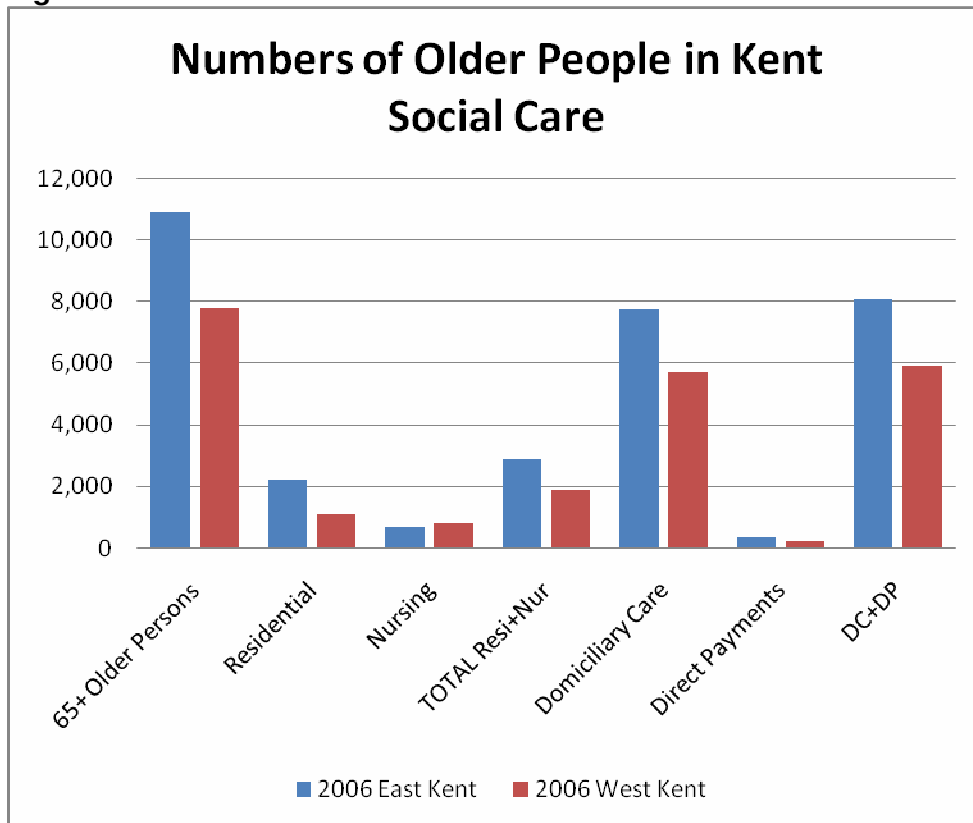


Figure 18

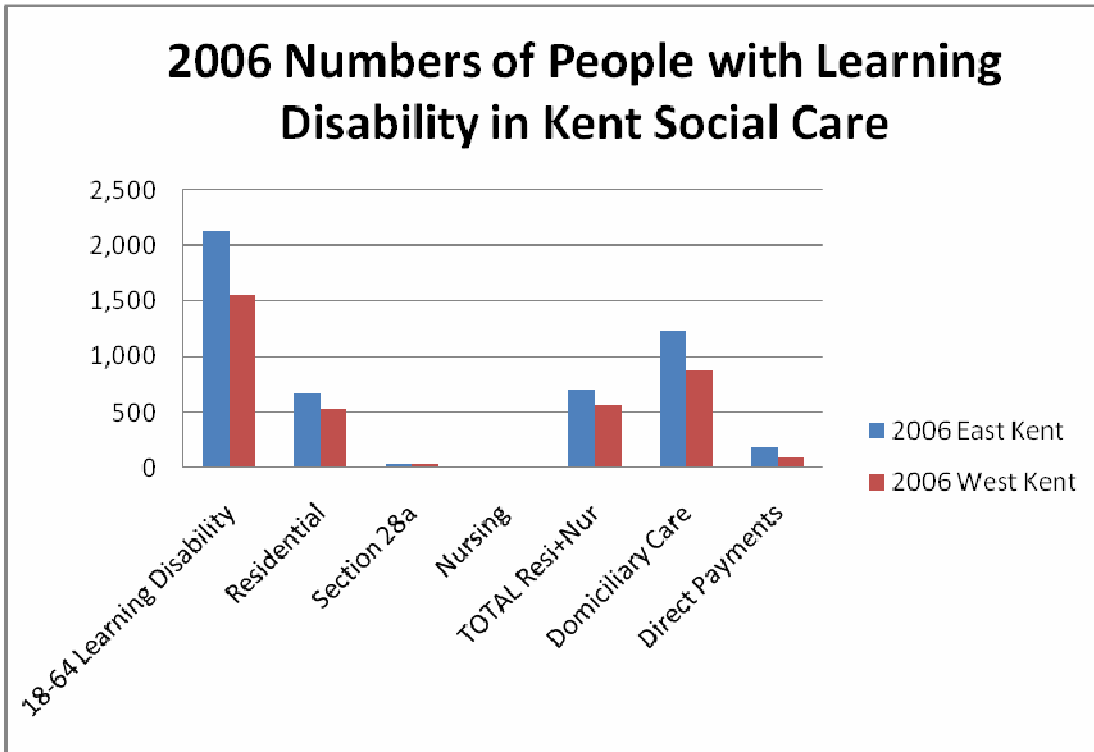
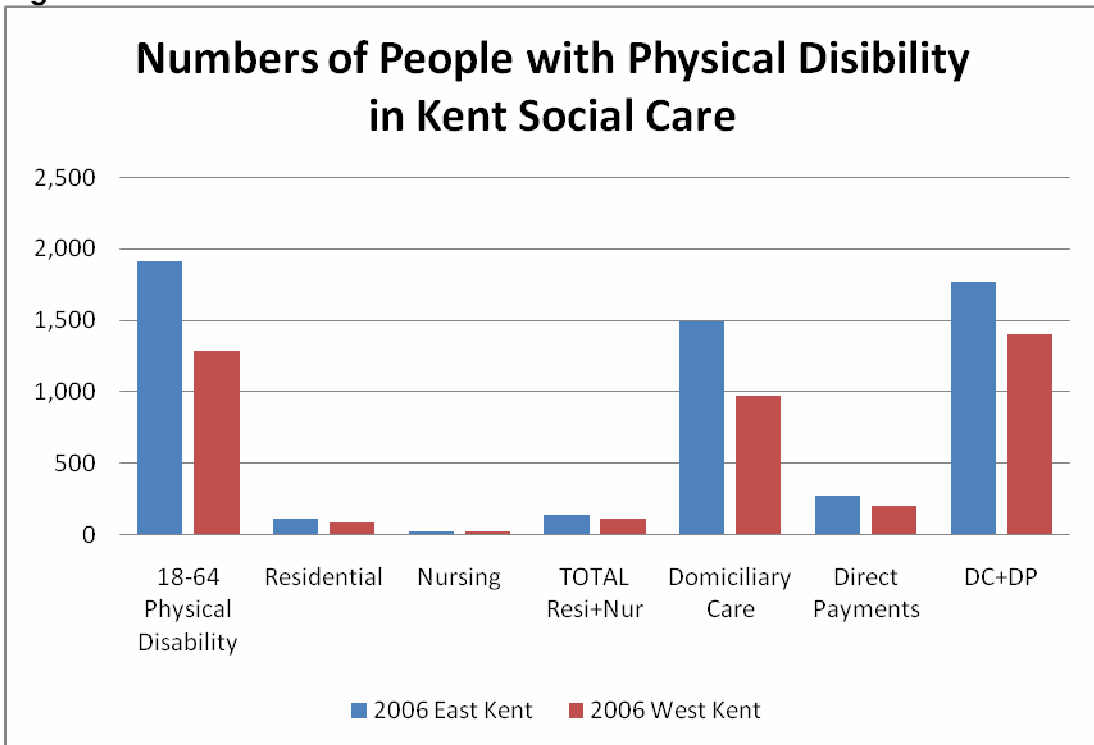


Figure 19



7.4 Mental Illness

Mental Health is one of the common reasons why people access their primary care services. Recent ONS survey results showed that 1 in 6 people (16.5%) complained about some form of treatable mental or emotional health problem relating to either anxiety or depression. These are called common mental illness. A far fewer proportion of these people will need drug or counselling therapy and even fewer again will need hospital or statutory help for their conditions. However it is estimated at around 20-40 people in every 1000 people will need some form of therapeutic intervention for common mental illness at primary care. Depression and anxiety are not only underlying contributors to many physical health problems but are often found to result from many long term conditions (e.g. cancer and hypertension). They are also often found together, and with other problems such as hazardous and harmful drinking, drug and substance misuse.

Severe mental illness (SMI) generally refers to psychotic or serious affective conditions (including schizophrenia and manic depression) but can also include dementia and psychotic depression. These are complex chronic conditions that need careful management in the community, often involving secondary care services, medication and social support. The accepted prevalence for these conditions is found to be stable across cultures and is found in around .05 -1% of the population.³ However, there is some correlation between incidence of acute mental illness and social deprivation. The University of Durham has developed the Mental Health Needs Index 2000 (MINI 2K)⁴ to calculate the predicted differential rates of psychiatric hospital admission per locality. This index is based on a number of indicators of deprivation for a locality (e.g. owning a car) and then applies that score to a statistical formula that links deprivation to admission rates.

In Kent predicted admissions from the MINI2K is correlate well with the actual admissions for the old PCT boundaries, although actual admissions are higher then predicted in the more deprived areas (fig 20). Most admissions are from Eastern Coastal, Medway and Dartford, Gravesham and Swanley PCTs and correlate with deprivation.

Dementia is also a major problem (Fig 21). This group of patients needs a wide range of support services to help them stay at home and give respite to carers. The large numbers living at home, set to rise with changing demography, present a challenge to statutory services and society as a whole. There is a need to both improve the level of existing services and plan additional support for growing numbers of sufferers, exacerbated by a dwindling availability of carers. It is recommended that existing support for dementia sufferers in Kent is reviewed and plans developed to meet the growing needs.

³ Meltzer et al ONS Psychiatric Morbidly Survey 2000

⁴ Glover,G. MINI2K University of Durham and NWPFO (check)

Figure 20

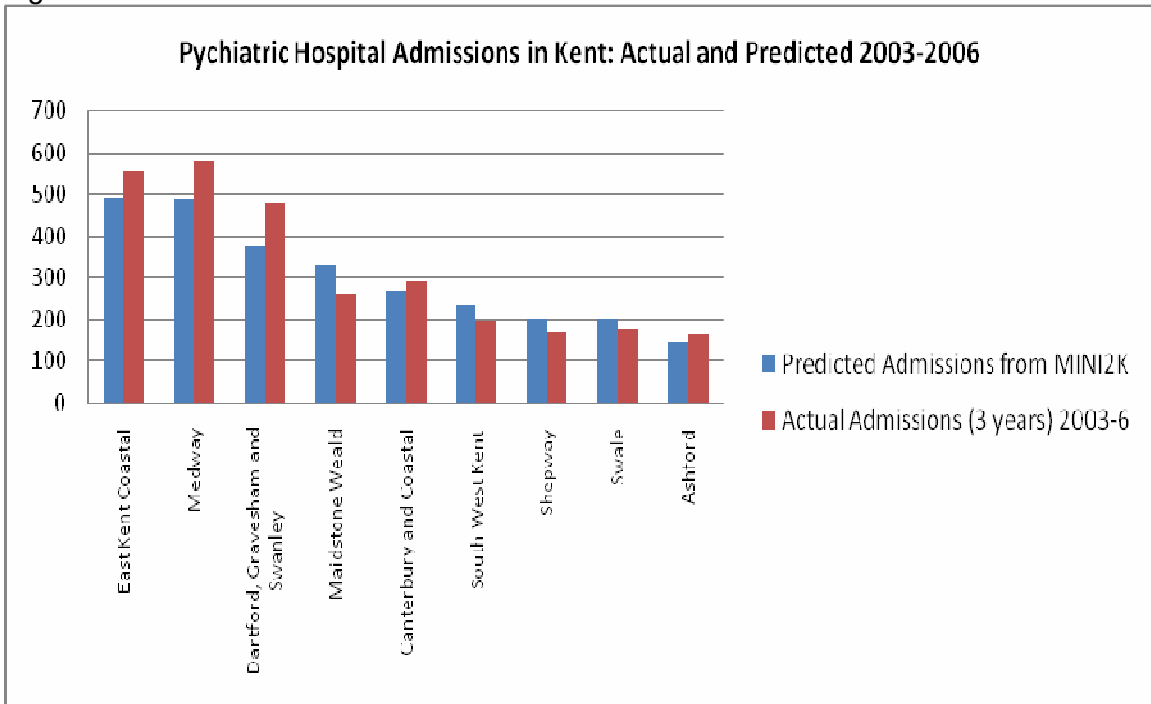
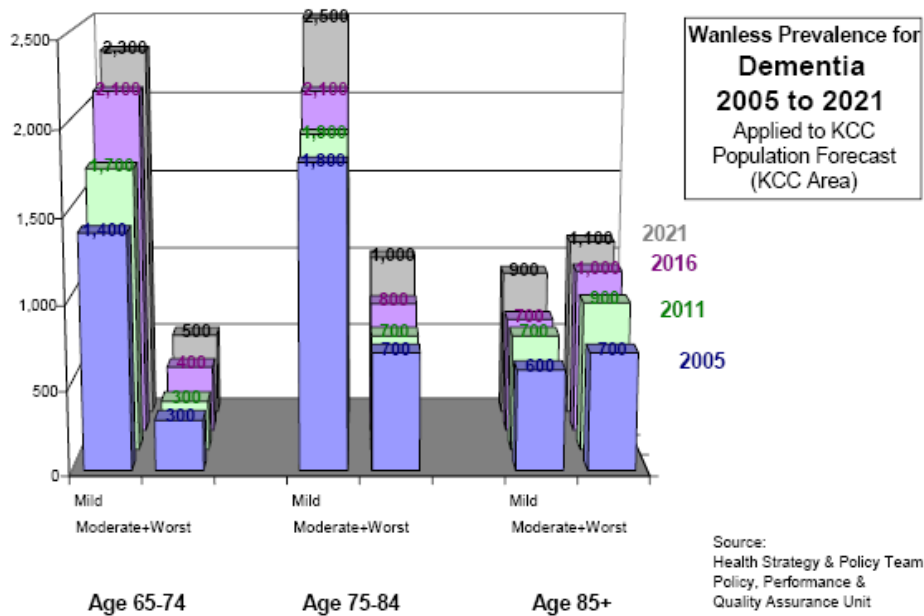


Figure 21



7.5 Mental Health Services

The Adult Mental Health Service Atlas 2003 (compiled nationally by Durham University) showed that Kent and Medway had an overall caseload of 11,290, with East Kent having slightly higher caseload. The caseload was 1193 per every 100,000 people, slightly

higher than the national average (1029 per 100,000 people). In 2003, there were 330 people in assertive outreach, and the case load has increased year on year from 2000 to 2003. There were 202 day care attendances per week, and 54 residential bed places, the vast majority in East Kent and 29 Psychiatric Intensive Care Beds, and 27 criminal justice referrals per 100,000 people. There were 887 people on the caseload of psychological counselling services in 2003, the vast majority in West Kent and higher than the national average.

By 2010 there are likely to be over 800 additional service users at an additional cost of £4.3m, and by 2016 there will be over 1700 extra people known to social services with a severe mental illness which could cost an additional £7m compared to the current budget.⁵ Part of the growth in people presenting with mental health problems is due to increased awareness. These projections assume that in time there will be full awareness. The rest of the increase is due to increased incidence of mental health problems and we have assumed that the growth in incidence will continue throughout the ten years.

It is recommended that an up to date full needs assessment is carried out on Adult Mental Health needs in Kent in 2008 in order to update the information presented here and to fully test the assumptions in the above forecast. The Director of Commissioning for Adult Mental Health for the lead Kent PCT for mental health (Medway PCT), Director of Public Health, and Director of Operations for KASS are jointly commissioning this work.

7.5 Impact of Health Inequalities

Over the next few years in Kent there will be a greater proportion of people in manual and routine work (who tend on average to be poorer paid) than people in other socio-economic classifications. By 2021, those in manual and routine work aged over 65 will have increased by 16% from 2001, whereas at ages 16-44, there will only be a 0.5% increase from 2001 to 2021. This means that in 2021, there will be a far higher proportion of the elderly population who are from more disadvantaged economic backgrounds. These groups will be far more likely to suffer from musculoskeletal and heart and circulatory problems than people from other socio-economic groups and over time will make up a larger proportion of the sick population over 65 in Kent. This again emphasises the importance of targeting health promotion and preventative activities at people now in their middle years.

7.6 Future Impact on Social Care

Future demands on social care services need to take into account three main things:

- population needs and changes;
- the resources and capacity to meet the demands; and
- appropriate design and delivery of services that are joined up with health care provision.

However, there are other factors which also impact on demand that are not so amenable to quantitative modelling. One such issue is people's rising expectations. This is in part

⁵ Projections made from current 2006 budgets and commissioner's forecast.

due to changes in national and local policy which increases people's choice and control (eg Direct Payments).

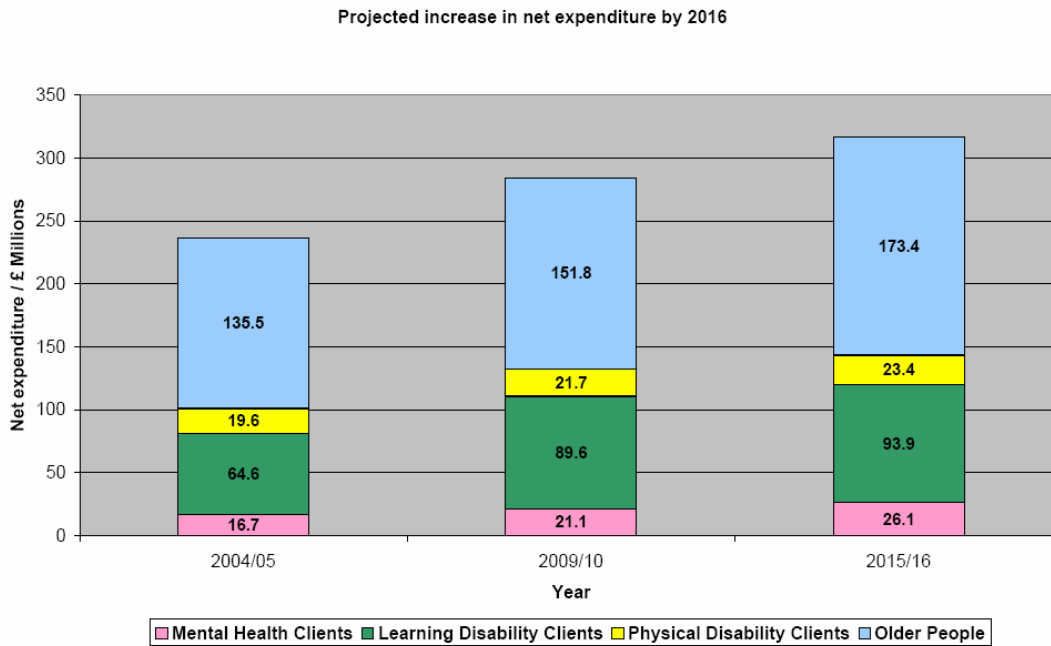
This report has highlighted the large scale of unmet need in the community for social care services. Kent has maintained the same level of eligibility for some years and yet there appears evidence to show that a larger proportion of this unmet need is currently being picked up by social services. This highlights that the pressures of service provision are not in the future, they are already being seen in the present services.

The total number of contacts made through the County Duty Service, which screens requests for social services support, rose from about 80,000 a year in 2005 to a projected 100,000 in the 2007-8 financial year. The number of *new* contacts has also been growing – referrals to care management increased by some 25% (from 22,493 to 28,190) between 2004 and 2007, and the proportion of those going on to have formal assessment for services has increased from 78% to 88%. This may reflect people accessing better information about available services prior to contacting County Duty.

If this recent rate of increase in demand continues, and services are provided at the current unit costs, the level of expenditure would become unsustainable (fig 21).

It is important to note that although the bulk of expenditure is on older people, it is the younger age groups that will cause the greatest financial pressure, particularly learning disability. This is because, although the numbers are small, medical advances lead to growing numbers of people with much more profound and complex needs surviving into adulthood and then into old age.

Figure 21.



Clearly, it will not be possible to continue to increase expenditure in this way, and in order to understand the impact of changes in the supply of social care and support

services, a data modelling exercise was carried out. This tested three different scenarios, all of which assumed that eligibility criteria remains at *moderate*, and that the overall proportion of the population receiving social care support remains constant. The different scenarios looked at how the additional people needing support might be distributed between different kinds of services:

1) “No change” – ie services would be delivered in the same proportions as currently. This would result in a 13% rise in demand over the next five years on all services.

2) “Residential and nursing care reductions” looked at 1%, 2% and 3.33% annual reductions in residential and nursing care, and what the corresponding increase in domiciliary care and Direct Payments would then be, given the demographic growth. A 1% p.a. reduction would result in a 19% increase in demand on domiciliary care (including Direct Payments) by 2012. A 3.3% reduction leads to an increase in demand for domiciliary care and direct payments of 14% by 2010.

3) “Best guess” was a more sophisticated and, probably, realistic scenario which modelled a rapid increase in Direct Payments (based on recent trends), 1% decreases per annum in residential care but no change in nursing care levels, and the resulting impact on domiciliary care of the demographic growth. For older people this would result in between 400 and 500 additional older people a year needing domiciliary care and Direct Payments (80-100 on Direct Payments every year and 330-400 with domiciliary care packages – although more Direct Payments would mean less domiciliary care packages and vice versa).

The modelling demonstrates the impact on social care of the demographic changes, and the relationship between reductions in residential care and increases in domiciliary care and direct payments. However, it doesn't reflect the potential reductions in demand that could be achieved by investing in services that prevent people from needing permanent social care support, such as intermediate care, recuperative care and “active care” (time-limited support provided in people's own homes specifically aimed at enabling people to regain their independence so they don't need ongoing domiciliary care or residential care). Investment in these services is an essential part of the strategy to reduce the demand for residential care. Such investment is better for individuals, resulting in improved outcomes and quality of life, and also makes economic sense as it reduces future demands for health and social care.

Moving services closer to home, providing increased support to remain independent for longer and increasing people's choice and control over their support may well also reduce people's use of health care services, so the overall impact on hospitals and primary care needs to be taken into account.

8. Management of Care Pathways: Equity and Prevention

This Joint Strategic Needs Assessment for Adults in Kent has already shown that as the population of Kent ages, the conditions that increase in people as they age will also

need to be planned for by both health and social care services. Apart from Cancer (which is the biggest killer of people before 75 years old), these conditions are notably coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), diabetes, conditions of the musculoskeletal (MSK) system (such as arthritis and back pain) and neurological conditions (such as dementia and Parkinson's). These conditions impact not only on health services (primary care and hospital) but also on social services care and support, particularly where they lead to older people becoming more sick and vulnerable for a longer time. Social Care also has additional issues of (a) an ageing population of people who need physical and learning disability services, some of whom have been cared by their families and those carers are also ageing, (b) growing numbers of profoundly disabled younger people surviving for many years and (c) rising expectations, driven in part by the personalisation agenda.

To cope with increasing demand, many services will need to be commissioned differently and their care pathways improved and re-configured. Many of the conditions listed above that impact on ageing populations are preventable (e.g. smoking is a key causal factor in both CHD and COPD and obesity often makes the management of diabetes and arthritis more difficult).

This section will illustrate and point to the way services are currently being used in Kent and may be able to highlight areas where improvements in the commissioning and care pathways can be made.

The key issue for both health and social care services is making services both more accessible and appropriate and for many conditions this means better primary and community services. GP services and primary care are critical to this. Ultimately, to get the most from the limited resources available for health and social care, it will be important to work with all partners, carers, patients and members of the community, to provide better opportunities for people to lead healthier lifestyles and plan and prepare for the physical and emotional changes that come with growing older.

8.1 Primary Care and Hospital Admissions

The main reasons for having a planned admission into hospital as an adult in Kent are for cancers, conditions of the musculoskeletal system and the digestive system. From April 2006 to March 2007 the main causes of emergency admissions were for injury and poisoning (which is appropriate) and circulatory diseases. In all cases, Thanet has the highest rate of emergency admissions. In East Kent, Shepway has the highest rate of elective (planned) admissions. In West Kent, Gravesham is high for both emergency and elective admissions, although Tunbridge Wells is high for MSK conditions and these two localities also feature as having high rates of emergency admissions. Dartford is among the localities with lower admissions.

It is interesting to note that in Thanet and Shepway's case, these are relatively deprived populations and the higher admission rates may reflect a higher prevalence of conditions in that area, whereas the pattern of admissions in Tunbridge Wells (a more affluent locality) is not so clear cut.

Looking at primary care QMAS data, although CHD is more prevalent in East Kent, there is a higher rate of admissions in West Kent. This pattern is also true for other conditions, apart from cancer. In East Kent, the admission rates follow the pattern of high

prevalence and deprivation, with Thanet and Dover having the highest admissions. However in West Kent, the areas with the highest prevalence for most conditions occur in the more affluent areas of Maidstone and Sevenoaks but with Dartford and Gravesham (the most relatively deprived localities in West Kent) having most of the admissions. This shows that either conditions are being managed well in primary care in the more affluent areas or there are some data issues in primary care in West Kent which needs some further investigation.

8.2 Technology (Telecare / Telehealth).

Arguably the biggest contributing factor to increasing life expectancy (aside from incomes) is technology. Improved technology in the form of better diagnostics (e.g. for cancer), better treatments (e.g. for heart disease) and better care (e.g. for Asthma and COPD) have had significant influence on people's quality of life.

Telecare provides support to people in their own homes with the help of technology and community response services. Trained operators are alerted within seconds of an accident or emergency and are able to respond in the best way. It has already brought reassurance to hundreds of users who wish to be able to live in their own homes for as long as possible. These people now have help available at a touch of a button, 24 hours a day, 365 days a year. The Telecare project in Kent aims to improve people's quality of life by helping vulnerable people manage the risks of living in their own homes. It enables people to retain their privacy and control over their individual lifestyles.

TeleHealth is aimed at people with long term chronic conditions, specifically Chronic Obstructive Pulmonary Disease, Chronic Heart Disease and Type 2 Diabetes. It is currently being piloted in Kent with 250 people using tried and tested equipment designed for this purpose which has an emphasis on ease of use. This enables people to measure their vital signs in their own home and send these through their home telephone to a community-based clinician who then monitors them much more frequently. This reduces frequent trips to clinicians in both the community and acute sectors, whilst helping people to better understand their condition and its impact on their daily living. Through doing this, the TeleHealth pilot appears to be reducing hospital admissions by increasing early interventions

8.3 Prevention

Health promotion and preventing illness (health improvement) is easier to do in areas that are relatively well off for a host of social and structural reasons. Targeting health messages to those who need it the most and tackling complex problems that cause health inequalities in deprived communities is harder. In Kent, the more affluent areas show the best health outcomes, and are also more than 10% higher than the national average on health improving programmes such as teenage conceptions and smoking (see Table 3). Clearly if greater improvement in the most deprived communities is the desired outcome then some targeting of services and pathways is needed in order to address the inequalities. Thanet, Swale, Shepway, Dover, Dartford and Gravesham need to be areas where prevention is more focused.

The biggest health concerns in Kent facing the ageing population are CHD & Stroke, COPD, Diabetes, Musculoskeletal conditions and neurological conditions. Reducing

smoking and obesity can have significant impacts on the severity and prognosis of most of these conditions.

Table 3

Health Measure	East		West		Kent	
	Best	Worst	Best	Worst	Best	Worst
Low Birth Weights (no national)	Dover	Thanet	Sevenoaks	Gravesham	Sevenoaks	Thanet
Teenage Conceptions	Canterbury	Shepway	Sevenoaks	Dartford	Sevenoaks	Shepway
Smoking	Ashford	Thanet	Sevenoaks	Dartford	Sevenoaks	Thanet
Binge Drinking	Shepway	Canterbury	Sevenoaks	Dartford	Shepway	Canterbury/Dartford
Healthy Eating	Ashford	Swale	Sevenoaks	Dartford	Sevenoaks	Swale
Obesity	Ashford	Swale	Sevenoaks	Gravesham	Sevenoaks	Swale
Suicides	Ashford	Dover	Ton & Mall	Gravesham	Ton & Mall	Dover
Cancer (Mortality under 65s)	Ashford	Thanet	Dartford	Tunbridge Wells	Dartford	Thanet
Circulatory (Mortality under 65s)	Ashford	Swale	Ton & Mall	Dartford	Ton & Mall	Swale

More than 10% Above National Average

More than 10% Below National Average

8.3.1 Mental Health

In many ways, mental health underpins our physical health and poor mental health can lower immune systems, lead to risky behaviours and poor and disrupted family functioning. One in four of the population suffers significant mental health problems such as depression and anxiety. Its improvement is also effected by actions in other key areas e.g. alcohol, physical exercise as well as wider determinants such as housing and employment. Levers to improvement are easier and more equitable access to psychological therapies, better range of therapies available in primary care e.g. guided self help and good links to community services and developmet.

8.3.2 Obesity

The health impact of obesity is substantial and preventable. There are opportunities for working with GPs, community pharmacies, leisure and exercise centres, and local authorities more widely to develop targeted programmes, a part of the care pathway approach.

Using the self-reported information from the CHSS Survey, the prevalence of obesity in Kent is estimated to be **14.3%** for men and **15.8%** for women, or **15.3%** overall.

Compared to a previous survey it appears that obesity has increased by 10.9% since 2001. Although increasing, it is lower than the national average. Due to problems of collecting survey data, these reported findings are likely to be underestimates.

The most important issue in these findings are that over half of the people with a BMI of 30+ reported a long standing illness or disability, such as asthma, arthritis, heart disease and diabetes, *twice as many as those with a BMI of under 30*. Also of those with a BMI exceeding 30, only 18.5% thought they were overweight. Levers to improvement for obesity are monitoring and tackling childhood obesity through better links between primary care and parental education, increasing opportunities for exercise and sport and proactive local Food Strategies.

Nutrition and Five a Day

On average 49.3% of survey participants said that they consume at least 5 pieces of fruit and vegetables a day. A lower percentage of men claim this level of consumption, 41.8% compared to 53.5% of women. When asked to comment on their general diet, 13% of all respondents admitted they were not eating healthily.

Physical Activity

Participation in physical activity is defined as at least 3 days a week x 30 minutes, the minimum amount recommended for maintaining good health. On average, in Kent, this level of participation is only achieved by less than 20% (1 in 5) of the population. The Figure above shows that there is variation between different Local Authority areas, with higher rates in more affluent areas and lower rates in more deprived areas. Nevertheless, even the best area, Tunbridge Wells, only achieves 23.2%.

8.3.3 Risky Behaviours

Another issue of major interest and concern is binge drinking and sexual activity, more likely to impact on younger adults. The individual long-term impact of poor sexual health is identified and multifaceted approaches developed through PCTs sexual health strategies and local authorities plan. Partnership working in the areas of alcohol, sexual health, substance misuse is substantial. Within this issue also lies the health risks associated with crime and disorder, notably domestic violence (the biggest risk of death and injury for women of reproductive age) as well as fear of crime which impacts on both elderly people and families (see Annual Public Health Report for more information).

8.3.4 Alcohol Consumption

The recommended weekly intake of alcohol is no more than 14 units for women and 21 units for men. However, in Kent 11.6% of males and 5.5% of females exceed this amount. The highest proportions of heavy drinkers are within the 45-64 age group for males (13.5%) and the 16-24 age group for females (9.7%), although alcohol abuse is increasingly seen across all adult age groups including older people. Anecdotal evidence suggests this is a growing problem, which is why there is to be an alcohol-related target in Kent Agreement 2 (the latest Local Area Agreement).

8.3.5 Smoking

Smoking is still the single largest preventable cause of death and ill health. It accounts for approximately 12,000 excess hospital admissions at a cost of in the region of £26

million per annum. PCTs are working with local authorities and other agencies to provide extensive programmes across a range of sectors e.g. tobacco control strategy to help people stop smoking. Daily smokers account for 13.8% of all males and 12.3% all females in Kent. The age group with the largest proportion of smokers is the 16-24 year olds for both sexes, with 19.5% of males and 18.9% of females of this age smoking daily. The percentage of smokers within the population decreases steadily as age progresses to leave only 6% of men and 4% of women over the age of 75 smoking daily.

Local survey smoking prevalence figures are much lower than those derived from larger surveys such as the General Household Survey (GHS) of 2005. This larger survey estimated prevalence to be 24%. The low figures reported in the local survey may be due to a poor response for this question or a lack of truthfulness in answering, a factor recognised by and allowed for in the GHS.

Smoking: Quitters

According to figures used to measure the Local Delivery Plan (LDP), only half of the target number of people giving up smoking for at least 4 weeks was achieved in Kent County in the latest quarter of 2006/07. Following the successes in this area in 2005/06, the subsequent targets are demanding and despite best efforts, organisations across the South East are facing difficulties in meeting the challenge averaging only 50% achievement toward the target.

8.4 Health Risk Factors in Older Age

Health promotion in the over 50s is highly cost-effective in reducing death and improving health in later life. For people aged over 75, falls are the leading cause of injury and death, with over 1,600 older people attending local A&E departments annually as a result. Increasing exercise throughout life has major benefits in old age through promoting independence, health and wellbeing.

Other important areas are diet and nutrition, reducing smoking, communicating health messages and involving older people in health planning, continued development of new technologies and assistive technology, and increasing the availability of intermediate healthcare and intensive home care.

8.4.1 Transport

Maintaining mobility is of great importance for the quality of life of older people. Older people may not have access to a car, whether through no longer being able to drive, or never having driven, or because of affordability. Those who have had to give up driving may be at a disadvantage because of a combination of frailty and lack of familiarity with public transport. Nearly half of households without a car are pensioner households.

Concessionary fares on public transport are very popular with older people and promote mobility. However, public transport facilities may be limited in rural areas. Innovative options should continue to be explored such as 'Dial a Ride' schemes, taxi-shares, and other ways of subsidising journeys for those in rural areas.

8.4.2 Housing

Aspects of housing are known to influence health. For example, those living alone may depend on help from family, friends or outside agencies, and may suffer from loneliness, isolation and lack of social networks. Living on the ground floor is preferable in helping prevent falls and hospital admissions, but this is not always possible. Lack of central heating is also a known risk factor for morbidity and mortality in frail older people, and fuel poverty and excess winter deaths are a particular concern. Schemes such as the Government's Warm Front programme may help to alleviate this problem.

50 years ago most older people lived in rented accommodation. Today most live in owner-occupied houses, an upward trend that is expected to continue. Nationally, the rate of home ownership is 71% (2004), with some areas reaching as high as 85%. Most older people in Kent own their own homes. However, older owner occupiers on modest incomes may often not be able to afford repairs. Around half of all people living in poverty are home owners. Most accidents experienced by older people take place inside the home; older householders on modest incomes are less likely to be able to ensure good standards of safety.

8.4.3 Nursing or Care Home Residents

Despite the popular belief that the majority of older people live in nursing or care homes, in reality only a minority live in these establishments. In the South East region, even in the 85 and above age group, just over 1 in 5 females and 1 in 10 males live in nursing or care homes. Current policies aim to help people to remain in their own homes, if that is what they want, and to provide more alternative options such as 'extra care sheltered housing' which has care available 24 hours a day when people need it, but people still have their independence and their own front door.

Conclusion:

Preventing illness, particularly for the most vulnerable, is not only ethical but makes sound economic sense in an environment of limited financial growth. Inequalities are a sign of considerable inefficiency and lend opportunities for service re-design in order to provide the right services for the right people at the right time.

Both Health and Social Care services face considerable challenges in the next 10 years to ensure that the services they provide are of the highest quality, timely, efficient and effective. As the above data and information show, the future is not far away - many of the pressures are being seen now. A clear joint commissioning approach will be fundamental in addressing the health and care of people in Kent, and the recommendations made in this report support that ultimate aim.