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Foreword

We have come together as health and social care partners across Kent and Medway to improve the services we provide and get the best possible health and social care outcomes for local people. It is important to understand where we are now, so that we can better understand where we can improve.

There is much to be proud of about health and social care services in Kent and Medway. Staff work very hard to provide high quality care and local people are relatively healthy compared with other parts of the country. Local organisations have a track record of working together to meet the needs of local people. But we have been delivering services in the same way for many years and, increasingly, this way of delivering services no longer meets the needs of local people, especially frail, older people, those with long-term health conditions and children and young people.

There are, therefore, several issues that we need to tackle in Kent and Medway; there are long waiting times for some services and the quality of care is not always as good as it could be. We also need to focus on reducing the need for health and social care, through ill health prevention, self-management, and earlier diagnosis. This case for change sets out our key challenges and will make sure that we target our efforts and resources to address these challenges in the coming years. The case for change highlights many challenges but we would like to highlight some of the key facts and figures:

- Over 1,600 local people die early each year from causes considered amenable to healthcare, with people in deprived areas and those with severe mental illness more likely to be affected.
- There are stark health inequalities across the area; for example, men living in the most deprived areas of Kent and Medway live on average 8 years fewer than those living in the least deprived.
- Only about 2% of health and social care funding in Kent and Medway is spent on public health interventions to reduce the risk of avoidable disease and disability (this includes nationally commissioned programmes as well as local ones). These budgets are expected to decline by 9% over the next 3 years (representing a decline of 3% per year).
- Over 1,000 (32%) people are in hospital beds that do not need hospital based medical care and could be helped elsewhere if services were more joined up and organised differently.
- People find it difficult to access GP services and there are a low number of GPs in Kent and Medway; there would be 245 more full-time GPs if we had the same numbers as the national average - and there are 136 vacant GP posts across Kent and Medway.
- For stroke patients who require thrombolysis, no acute trust in Kent and Medway delivers this treatment to all patients within the national guideline recommended time of 60 minutes; in 2015/16, the worst performing trust thrombolysed just 16% of patients within 60 minutes.
- The health and wellbeing of children and young people could be better. Around 1 in 5 primary school children are overweight or obese and the number of teenage pregnant mothers is above the regional average. As well as this, half of all looked after children are defined as being a ‘cause for concern’ and are at greater risk of developing mental ill health.
- Local health and social care commissioners and providers are facing a £110m deficit in 2016/17 which will rise to £486m by 2020/21 if nothing changes.

We are committed to working together to make sure that local services are as high quality and as accessible as possible. We will make sure that we prevent disease where possible, that we meet the needs of all local people and that we provide high quality services for all.
There is a clear distinction between meeting ‘patient needs’ and meeting ‘patient wants’. In this case for change we have sought to identify and highlight the needs of the population so that we can address the issues facing them. Delivering on ‘patient wants’ may not necessarily mean improved outcomes. This case for change describes the local context, the changing health and care needs of local people, and the key challenges facing health and care services in Kent and Medway. This document does not contain solutions but will be used to guide our understanding of where we need to transform local services over the next few years.

A group of senior doctors, nurses and care professionals have worked together to develop this document which we hope will show where we can improve health and well-being and make local services better. We believe that every person in Kent and Medway should receive the same high quality standard of care. This will mean that we need to work more closely together to prevent ill health where we can and provide integrated, high quality services when people fall ill. We recognise that we will need to work together to achieve this.

Signed by

Andrew Scott-Clark, Director of Public Health (Kent County Council)

James Williams, Director of Public Health (Medway Council)

On behalf of the Kent and Medway Clinical Board and Professional Board

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March 2018
1. Executive summary

This case for change document describes the changing health and care needs of local people and the key issues facing health and care services in Kent and Medway. It will be used to guide the transformation of local services to improve care and quality over the next few years.

Kent and Medway comprises eight CCGs – Ashford, Canterbury & Coastal, Dartford Gravesham & Swanley, Medway, South Kent Coast, Swale, Thanet and West Kent – which cover the areas of Kent County Council and Medway Unitary Authority. There are around 1.8 million residents in Kent and Medway and the area spends over £3.5bn on health and social care. There are seven acute hospitals, three providers of community services and three providers of mental health services, as well as 249 GP practices and around 466 social care providers.

The needs of local people drive local requirements for health and social care:

- **The local population is growing rapidly:** From 2011 to 2031, planned housing developments are expected to bring an additional 414,000 people in Kent and Medway in 188,200 new homes\(^1\); 10,000 of these new homes will be in the new town in Ebbsfleet\(^2\). This growth will be distributed unevenly across Kent and Medway, with most housing growth occurring in Medway, Dartford and Maidstone.

- **Local people are living longer and older people tend to have additional health needs:** the number of older people is growing quickly and older people tend to use health and social care services more than other age groups. Growth in the number of over 65s is over 4 times greater than those under 65; an ageing population means increasing demand for health and social care. There are also around 12,000 people with dementia in Kent and Medway.

- **There are widespread inequalities across Kent and Medway:** for example, men residing in the most deprived areas live on average 8 years fewer than those living in the least deprived. Some areas show less health inequality and evidence shows that poorer regions tend to have worse health and lower life expectancy. Health outcomes are therefore not homogenous across the region and there is significant variation. The main causes of early death are also often preventable.

- **People are living in poor health with preventable long-term conditions:** over 528,000 local people (including 19,000 children under 16) live with one or more significant long-term health condition\(^1\), many of which are preventable; and many of these people have multiple long-term health conditions, dementia or mental ill health. On average, total spend on a person in Kent and Medway with a long-term condition is 6 times more than on a healthy person, the cause of this being a lack of support for patients to manage their own healthcare and often intervening too late once their condition has deteriorated.

- **There are differing levels of health and social care needs:** the majority of local people are largely healthy, but there is high use of health and social care by those with long-term conditions, severe mental illness, learning disabilities, severe physical disabilities, dementia and cancer.

- **Many people (including children) have poor mental health, often alongside poor physical health:** the prevalence of mental health disorders in Kent and Medway is generally in line with the rest of England, but mental health problems disproportionately affect people living in the most deprived areas in Kent and Medway. Approximately one in ten children aged 5 to 16 has a diagnosable mental health problem (this is similar to the national average), and

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\(^1\) Including severe mental illness, dementia, cancer, physical disability, learning disability, asthma, coronary heart disease, chronic kidney disease, chronic obstructive pulmonary disease, depression, diabetes, epilepsy, heart failure, hypertension and stroke.
there are many ‘at risk’ groups including children living in deprived households. Self-harm can be a useful mental health indicator and in Kent and Medway, self-harm rates have risen since 2007. In Kent, there was an estimated 5,920 people with a hospital admission for self-harm. In Medway, there were 577 emergency hospital admissions for intentional self-harm.

- **The health and wellbeing of children could be better** especially as it is a significant determinants of physical and emotional wellbeing all the way through to adulthood. The issues facing children and young people include 1 in 5 being obese or overweight, inadequate vaccination coverage with less than 90% being vaccinated for measles, mumps and rubella, and just under half of all looked after children being at higher risk of developing a mental health disorder. Clinical standards for paediatric and maternity services are also not being met, with only one in four trusts delivering more than 90% of nationally agreed standards. This all results in patient experiences being inconsistent across Kent and Medway with no trust receiving an overall patient satisfaction rating of greater than 8.5 out of 10, the national average.

This suggests that the priorities for focus are ill health prevention, older people, those living in the most deprived areas, those living with long-term conditions and people with poor mental health. It is also important to make sure high quality services are available both for those with continuing needs and when required for the majority of local people who are generally healthy. The health and wellbeing of children and young people should also not be forgotten especially as it is a significant determinant of health and wellbeing in adulthood and is a vital component of any clinical strategy.

There are challenges in the delivery of care and quality:

1. **There is not enough focus on maintaining independence and ill health prevention across the whole Kent and Medway system (including physical health, mental health, social care and the wider public sector):** many people in Kent and Medway are not currently ill, but are at risk of developing long-term health conditions such as diabetes and heart disease. Between 2014 and 2016, there were around 9,200 deaths that were from causes considered preventable and that could have been avoided if more effective public health interventions had been in place. Many of the indicators of future poor health (for example, obesity and smoking) are worse than the national average in Kent and Medway, especially in more deprived areas. There is an opportunity to focus on keeping people healthy through the prevention of disease and ill-health and maintaining independence. However, only about 2% of health and social care funding in Kent and Medway is spent on public health interventions to reduce the risk of avoidable disease and disability (this includes nationally commissioned programmes as well as local ones).

2. **There are challenges in primary care provision, which is extremely fragile in some areas:** some local people are unhappy with existing GP services; for example, almost 1 in 3 people surveyed in one area of Kent and Medway would not recommend their GP surgery. This may be partly explained by poor access to GP services and long waiting times once patients are in the surgery. Poor access is partly driven by a lack of capacity in primary care – there would be 245 more GPs and 37 more practice nurses in Kent and Medway if the area had the same numbers as the national average - this lack of capacity is greatest in the most deprived areas. However, it is difficult to recruit new GPs; there were an estimated 136 open GP vacancies in September 2016 across Kent and Medway (12% of the total number of GPs) – this also means there are large numbers of locum GPs. The fragility of primary care provision can lead to disease not being detected early enough, increased activity in hospitals and pressure on mental health services. It can also mean that there is insufficient capacity to introduce long-term solutions that promote health and wellbeing, such as prevention clinics and teaching patients how to better manage their own healthcare.
3. **There are gaps in service and poor outcomes for those with long-term health conditions:** there are over 528,000 people in Kent and Medway with significant long-term conditions; most of these are older adults and many have multiple long-term conditions. Many local people do not get enough support to manage their conditions and end up going to hospital too often as a result. Evidence suggests that hospitalisations can be reduced by as much as 25-40% if there was better support for self-care and early intervention to prevent people deteriorating. Carers are also not receiving enough support; fewer than half of local carers are satisfied with their experience of care and support. At any one time there are 150 acute beds occupied by people recovering from a fall.

4. **Many people are in hospital who could be cared for elsewhere:** every day over 1,000 people are in local hospitals when they could be elsewhere. Longer stays are not always driven by medical need. Discharging people appropriately from an acute hospital speeds recovery and reintegration back into their social networks. Some of the main causes of delay include awaiting a care home placement (14%) or awaiting a care package in their own home (14%). As well as this, inefficiencies within the hospital itself can also result in significant delays. Whilst great gains have been made, particularly in Medway where they have introduced innovative measures to reduce the number of delayed transfers of care by as much as 25% over a three month period, we need to replicate these success stories across the whole of the region.

5. **The quality of care homes is also an issue:** the majority of patients who are medically fit to leave hospital but require basic essential care such as feeding and washing are confronted with two problems, there is either a shortfall of available beds to accommodate them or they are faced with a substandard level of care when eventually placed. 41% of residential social care organisations in Kent and Medway are inadequate or require improvement and there has been a significant reduction in nursing home places with no less than 25 homes closing in the last two years. In September alone, three care homes housing up to 50 residents closed across Kent and Medway due to poor quality of services and conditions. More can be done, and there is opportunity for care organisations to learn from those who are performing relatively well in the region, reducing the variation in the quality of social care that is provided in Kent and Medway.

6. **Some local hospitals find it difficult to deliver services for seriously ill people:** some services are vulnerable and potentially unsustainable. There are some services for seriously ill people in Kent and Medway that are small, and senior staff and specialist tests and equipment are not available 24 hours a day. There are also issues with services outside hospital, particularly at weekends, making it difficult for people to go home when they are able. This leads to delays along the patient pathway, including: waits to be seen by a senior doctor, for diagnostic tests, for a hospital bed, for treatment and to leave the hospital. There are particular issues in stroke, vascular and acute medicine. These challenges also result in poor access for patients; all trusts in Kent and Medway are in the bottom 30% when it comes to patient satisfaction scores across the country for A&E. However, even if there were unlimited funds, there are simply not enough qualified and experienced staff to deliver services and some providers are having problems recruiting and retaining staff with vacancy rates of as much as 19% across particular staff groups.

7. **Planned care is not delivered as efficiently and effectively as it could be:** it should be possible to standardise planned care across Kent and Medway according to best practice and therefore to improve outcomes while also reducing costs. However, in Kent and Medway, the level of referrals from GPs to hospital specialists are higher than other places with a similar population; if the level of referrals were the same as top performing CCGs in similar areas, outpatient activity would reduce by 9%. If planned activity within hospitals were the
same as top performing CCGs in similar areas, it would reduce by 14%. There are also differences between hospitals in the delivery of planned care. On average over a third of patients having a hip replacement stay in hospital for longer than 3-days and there is a potential opportunity to reduce this. One potential cause of differences in the delivery of planned care is levels of emergency care. In Kent and Medway, emergency activity is increasing and this can lead to issues in delivering planned care as there is a limited number of beds to admit patients.

8. There are particular challenges in the provision of cancer care: there are many opportunities to save lives and deliver cancer services more efficiently. Cancer is a major cause of death in Kent and Medway and survival rates could be much better. Mortality from cancer in Kent and Medway is similar to other parts of England. However, compared to other countries such as Sweden, the UK has much lower survival rates. Late diagnosis of cancers is a particular issue in Kent and Medway, as is low take-up of screening for cancer in areas of deprivation. Once cancer is suspected, waiting times to see a specialist and then for treatment are long across Kent and Medway. Evidence shows that late diagnosis of cancer is directly linked to reduced patient outcomes and a lower likelihood of treatments working.

9. People with mental ill health have poor outcomes and may not always be able to access services, particularly when having an acute crisis: there is strong evidence of the relationship between poor physical health and mental illness. People with a serious mental illness are at risk of dying on average 15 to 20 years earlier than the general population. Nationally, spend on mental health does not reflect the need for services. There is widespread dissatisfaction with services, particularly for crisis care and changes in who the person sees.

10. There is a substantial financial challenge facing health and social care organisations in Kent and Medway and services could be run more productively. Although local providers have comparable levels of efficiency to hospitals of a similar type in many areas of spend, and some are amongst the most efficient, all providers in Kent and Medway could do more to reduce costs and run services more efficiently. It is estimated that approximately £190m of savings could be made if services were run as efficiently as top performing hospitals of a similar type. This is important as commissioners and providers in Kent and Medway will be £486m in deficit by 2020/21 if nothing changes. National initiatives such as the Carter review, Model Hospital and ‘Getting It Right First Time’ (GIRFT) offer many opportunities for hospitals to learn from best practice and standardise the way they work in order to be more efficient. It is important for Kent and Medway to be involved in this work in order to replicate the productivity and quality gains that are being observed in many other parts of the country.

There are a number of key enablers that will need to be in place to allow us to transform services and improve health and social services for local people. These include:

- The ability to recruit and retain a qualified and experienced workforce across health and social care. There are currently high levels of vacancies, high turnover and high numbers of temporary staff across some areas in Kent and Medway. There is also a shortage of some skilled staff in some areas and there will not be enough skilled staff to meet the future health needs of individuals and communities.
- High quality, fit for purpose estates that are utilised as fully as possible. The quality of estates in Kent and Medway is variable and there are issues with under-utilisation of some hospitals, particularly in the community.
The information technology and information management systems that will allow us to deliver high quality and efficient care across organisational boundaries. All organisations in Kent and Medway believe they do not have the IM&T capabilities required.

This case for change suggests several priority areas for focus, including:

- Health promotion and ill health prevention, particularly around those who are healthy and well but are at risk of developing long-term health conditions. Investment in preventing ill health will be crucial to achieve this.
- Recruitment and retention of primary care staff, especially GPs.
- Avoiding hospital admissions for people with long-term conditions and supporting their carers.
- Reducing the length of stay in hospitals especially for older people, in partnership with social care.
- Specialised services which need to be configured so there is sufficient senior workforce to continue to provide high quality services. This needs to be balanced against the need to provide local access to services, where possible.
- Reducing differences in referrals into planned care, and the differences in the delivery of planned care within hospitals, including the relationship with emergency services.
- Improving efficiency, quality and access on the cancer pathway across primary and acute providers.
- Provision of mental health services, particularly the physical health of those with a mental illness, early diagnosis and access to integrated services.
- Improving productivity across all providers in Kent and Medway.

Across Kent and Medway there are many examples of excellent work taking place to improve the way people are cared for. While these improvements are promising, they are only happening in some parts of Kent and Medway. The changes we need to make are greater than those already made, and so we must work together on a scale greater than we have before. Health and social care commissioners and providers across Kent and Medway have therefore come together to create a 5-year Sustainability and Transformation Partnership (STP). As part of this plan, we are exploring and pursuing opportunities around four key themes: care transformation, productivity, enablers and system leadership. This Case for Change fits within the wider clinical strategy which includes developing a clinical vision that describes how we want to deliver health and care within Kent and Medway and creating new frameworks for various care models with an emphasis on the enablers needed to achieve this.

We will focus more on preventing ill-health and promoting good health and our local care will improve the health of people in Kent and Medway. We will work with local people to transform local care through the integration of primary, community, mental health and social care. Hospital care will need to change to improve patient experience and outcomes; make best use of the available workforce; and make best use of our buildings. With these plans, we are confident that we can overcome the challenges which our health and care system faces and provide high quality services and outcomes for local people. This work will be overseen by the Clinical Board and Professional Board which includes GPs, hospital consultants, nurses, public health professionals, social care leads, pharmacists and other clinical experts. We will work with them to develop an overarching clinical vision for Kent and Medway that gives us a clear description of how we want health and social care to be delivered. This is an ambitious plan of work and we are committed to progressing it for the benefit of local people.
2. Context

2.1 The local area

Kent and Medway comprises eight CCGs – Ashford, Canterbury & Coastal, Dartford Gravesham & Swanley, Medway, South Kent Coast, Swale, Thanet and West Kent – which cover the areas of Kent County Council and Medway Unitary Authority. It includes the city of Canterbury (population c.160,000) in the east, the large market town of Maidstone (population c.165,000) in the west, and the large conurbation of Medway in the north. Medway’s main towns are Strood (population c. 33,000), Rochester (population c. 27,000), Chatham (population c. 70,000) and Gillingham (population 100,000)\(^4\). This large geographical area (1,368 square miles)\(^5\) includes many smaller towns and villages and rural areas, and borders with London in the north west. Kent and Medway has a very long coastline which gives rise to challenges in providing accessible services. The number of people living in Kent and Medway is approximately 1.8 million\(^6\).

\[\text{Exhibit 1 – Map of Kent and Medway}\]

Source: Image obtained from Wikimedia Commons

2.2 Commissioners of services

Health services in Kent and Medway are commissioned on behalf of local people by the eight local CCGs and NHS England. Social care services in Kent and Medway are commissioned by Kent County Council and Medway Unitary Authority. NHS England commissions specialist services such as major trauma, kidney transplants, eating disorders, plus primary care services (GP primary care services are co-commissioned with CCGs in some areas) whilst the CCGs commission all other health services including mental health, hospital and community.

Health and social care spending on the residents of Kent and Medway was £3.5bn in 2016/17. Of this, 48% was spent on hospital care including specialised commissioning, 16% on social care, 19% on primary and community services, 6% on mental health, 9% on prescriptions and 2% on public health (this includes nationally commissioned public health initiatives such as immunisations, vaccinations and public health programmes)\(^7\).
We can see below that there are slight differences in how other STP footprints spend their money as well as how spend is allocated on a national level. Social care and public health spending for example is lower but primary and community care spending is higher in Kent and Medway. How spend is allocated going forward should reflect the priorities in which the STP choose to pursue, a focus on prevention for example will require more investment on public health.

Source: NHS England, NAO and DCLG
2.3 Providers of health and social care

There is a complex range of organisations providing these health and social care services in Kent and Medway, as shown in Exhibit 4.

Exhibit 4 – Kent and Medway overview

There are 249 GP practices, 394 dentists, 157 opticians and more than 335 pharmacies in primary care and around 466 social care providers. Out-of-hours primary care services are delivered by Integrated Care 24 (IC24) in East Kent, West Kent and Dartford, Gravesham and Swanley. Medway on Call Care (MedOCC) provide out-of-hours primary care services in Medway and Swale.

There are several mental health providers which provide inpatient mental health facilities, community mental health teams, liaison psychiatry into hospitals and a range of specialist mental health services. These are:

- **Kent and Medway NHS and Social Care Partnership** which provides inpatient, outpatient and community mental health services for anyone aged 14 and above, and other services including forensic mental health, learning disability, substance misuse and a range of specialist services.
- **Sussex Partnership NHS Foundation Trust** which provides children and young people’s mental health services for children and young people who have emotional, behavioural or mental health problems. They also have a Children in Care (CIC) team dedicated to providing support for looked after children across Kent and Medway and specialist inpatient beds for children and young people with mental health problems.
- **South London and Maudsley NHS Foundation Trust** which provides specialist inpatient beds for children and young people with mental health problems.
There are three community providers which deliver a range of services including inpatient community beds, stroke rehabilitation beds, intermediate care beds, urgent care, diagnostics, outpatients and minor surgery and community teams including community nurses, health visitors and a range of therapists. There are also 13 community hospitals in Kent and Medway providing 294 community inpatient beds. The providers are:

- Kent Community Health NHS Foundation Trust which provides a range of community care services in Kent, East Sussex and Newham.
- Medway Community Healthcare CIC which provides a range of community health services in Medway and Kent.
- Virgin Care which provides community nursing, community hospital services, intermediate care, community falls service, speech and language therapy and podiatry in north Kent.

East Kent Hospitals University NHS Foundation Trust also provide community services at two hospitals. There are a range of social care services provided by local authorities, including home care, meals, transport and home modifications. There are 303 privately run residential and nursing care homes in Kent, who provide both health and social care.

There are four hospital trusts providing acute hospital services including A&E, emergency and elective (planned) surgery, acute stroke services, consultant-led maternity services and inpatient children’s services plus a range of specialist services. The trusts are:

- Dartford and Gravesham NHS Trust which provides acute hospital services predominantly from one site in Dartford and a range of planned, urgent and community care services from three other sites in the local area – two of which cross into south-east London.
- East Kent Hospitals University NHS Foundation Trust which provides acute hospital services from three sites in Ashford, Margate and Canterbury and also provides outpatient and diagnostic services from two community hospitals in Folkestone and Dover. It also offers a range of services throughout the local area in facilities owned by other organisations and runs renal (kidney) services in East Kent, Medway and Maidstone.
- Medway NHS Foundation Trust which provides acute hospital services predominantly from Medway Maritime Hospital in Gillingham, and offers a range of surgical specialities, such as the West Kent vascular service.
- Maidstone and Tunbridge Wells NHS Trust which provides acute hospital services predominantly from two sites in Maidstone and Tunbridge Wells, and a full range of general hospital services and specialist cancer care.

A number of people travel from outside Kent and Medway to use services in Kent and Medway hospitals. For example, over 20% of the people who are seen at Tunbridge Wells Hospital for planned care are from outside Kent and Medway.

Travel distances between acute hospitals in Kent and Medway are generally less than an hour, except for the Queen Elizabeth, The Queen Mother Hospital in Margate, which is more remote from other hospitals. People living in Kent and Medway also go outside the area for some routine care and also some specialist treatments, for example, burns care in East Grinstead and liver transplants in London. These specialist treatments are not covered by this case for change.

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2 These four sites are not included in the Sustainability & Transformation Partnership footprint.
2.4 Local successes

There are many services in Kent and Medway that provide high quality services every day and will continue to do so. The NHS and social services in Kent and Medway have also already had a number of successes making changes to local services to deliver the needs of the local population. There are many examples of how local services are starting to implement new ways of delivering care. Some of these are listed below.

Example 1: Therapeutic staffing in mental health
As a result of national nursing staff shortages, high levels of agency usage, and being committed to the parity of esteem agenda, KMPT have reviewed staff and skill mix on inpatient wards. The purpose of this is to ensure a therapeutic environment is achieved and maintained, giving maximum opportunity for timely acute recovery through available occupational, psychological, nursing and medical care. This has included the development of a hybrid Band 3 role with the aim to release "Time to Care", extending access to the therapeutic programme (beyond 9-5 Mon-Fri) and ensuring staffing reflects peak demands such as late afternoon/early evening when there is an increase of admissions. Physical health nurses are included in the staffing complement, with career progression opportunities enhanced with the newer development of not only Band 5, but also Band 6 physical health nurses. The quality impact assessment completed in East Kent’s pilot demonstrated a positive impact on multi-disciplinary working, patient experience and an improved range of therapeutic activities being offered to patients across the week.

Example 2: Improving patient flow and reducing external placements in mental health
The KMPT Chief Executive set a target to reduce private bed usage to zero by the end of the year. A weekly Programme Board was set up to achieve this, focusing on a number of work streams to improve patient flow. These work streams include initiatives to improve cross service line working, focus on patients with a Personality Disorder and ensure MDT review of complex cases. One of the most successful work streams has been setting up a daily patient flow conference call (including discharge planning). This call allows clinicians to review their caseload, escalate any issues, share best practice and consider alternative options for patient care allowing MDT discussions. In the six months to December 2016 the focus on patient flows within KMPT resulted in a significant decrease in the number of external placements (from 72 beds to 4).

Example 3: Diabetes Prevention Programme
The NHS Diabetes Prevention programme (NDPP) is the first attempt to prevent Type 2 diabetes at a national scale anywhere in the world. Medway CCG and Medway Council’s Public Health team were one of the seven demonstrator sites to pilot this work. The learning from the pilots, including the adoption of a primary care case finding tool developed in Medway, has been used to inform the wider roll out across England. The South East was one of the first wave of roll out areas in England to start referring into ‘Healthier You’, which aims to support those at risk of developing Type 2 diabetes to make healthier lifestyle choices. The South East clinical network is now working with 20 CCGs and 6 Local authorities across the South East in partnership with Ingeus (the course provider) to roll out the programme, so anyone referred can attend a course near to their home or work. The NDPP is continuing in Medway and has been successfully rolled out across Kent as of April 2017. Of the 75 patients who have already completed the course in Medway 70% of them reduced their HbA1c (glycated haemoglobin) and therefore their risk of developing diabetes.

Example 4: The use of a computerised clinical decision support system (CDSS) in primary care
East Kent University Hospitals Trust has implemented a CDSS in primary care to support the identification and management of chronic kidney disease. Since 2005 the CDSS has screened patients having serum creatinine (SCr) estimations (a test done to show how well kidneys are
working). Data are regularly extracted from primary care databases and patient specific advice is given regarding referral, medicines management and further investigation. As a result, a study shows that this has significantly reduced the incidence of late referral to renal replacement therapy among patients with renal failure. This has important implications for patient outcomes, as late referral is associated with higher mortality, and people who are referred late are more likely to be denied treatment choice, pre-emptive renal transplant is usually not feasible and starting renal replacement therapy is less likely. Furthermore, the same system, combined with pay for performance, saw an improvement in blood pressure control in people with chronic kidney disease (from a mean of 146/79 mmHg to 140/76 and then to 139/75 mmHg over 4 years of follow up).

**Example 5: Reductions in smoking prevalence**

In the first six months of 2017, Kent and Medway displayed the highest success rates for people quitting smoking on record for the whole of England. In Kent, 65% of smokers who attended drop in clinics managed to quit smoking and in Medway, 58% of smokers who used telephone support services managed to break the habit as well. These local initiatives combined with broader national drives such as Stoptober has meant that smoking rates across Kent and Medway have fallen by more than 5% since 2012. In Kent, just 15.2% of the adult population now smokes and in Medway the number of smokers is less than one in five at just 19%. The variety of stop smoking services that are on offer within Kent and Medway supports the evidence showing that the likelihood of quitting is greater when there is support available at the local level rather than just going it alone. However, there is still more work to be done. Tobacco is still the number one cause of death in England with an average of 25% of hospital beds occupied by a smoker at any one time. In 2015/16, smoking relating hospital admissions in Kent accounted for just over 12,400 people and in Medway just over 2,100. Encouraging people to stop smoking results in huge benefits for the individual as well as financial savings for the health service.

**Example 6: Sustained reduction in teenage pregnancy rates**

Reducing teenage pregnancy is a national as well as a regional priority across Kent and Medway. KCC’s Teenage Pregnancy Strategy covering 2015-20 specifically states ‘improving sexual health for young people’ and ‘building emotional resiliencies’ as key ambitions to achieve in the years ahead. Evidence shows that babies born to teenage mothers have a 60% higher infant mortality rate and a 63% increased risk of being born into poverty. Children born to teenage mothers also do less well at school and show early disengagement from education and learning. Measures to tackle teenage pregnancy will therefore help reduce these social and health inequalities as well as combat child poverty. The under 18 conception rate has been steadily declining in Kent and Medway and is as a result of years of multiagency collaboration to ensure third sector organisations, school nurses and clinicians work together to deliver services tailored to young people including sexual health education and career advice to build aspirations. However, more can be done particularly in Medway where in spite of the declining trend the under-18 conception rate sits above the national average and in Kent where it is still above the regional average.

These kinds of improvements have helped the local health and social care system to change and adapt to provide good services for local people, but more still needs to be done to respond to local needs and consistently deliver the highest quality of care and ensure value for money.
3. The needs of local people

Everyone in Kent and Medway has a different need for health and social care services. Some need intensive support and care (for example, in the final years of their lives) whilst others access services very infrequently (perhaps just to see a GP for common illnesses). Much of this need depends on demographic factors such as age, deprivation and personal wellness, but it also depends on whether people are living with one or more long-term health condition such as asthma, cancer, dementia or mental illness. To understand the changing needs local people in Kent and Medway, it is important to understand the needs of local people.

3.1 The local population is growing rapidly

It is anticipated that the local population will grow rapidly over the coming years as there is substantial housing growth planned in many parts of Kent and Medway. From 2011 to 2031, planned housing developments are expected to bring an additional 414,000 people in Kent and Medway in 188,200 new homes; 10,000 of these new homes will be in the new town in Ebbsfleet. This represents a 24% increase in population, of which 18% is attributed to demographic growth and 6% is incremental. By comparison, the population of England is expected to grow by only 14% in the same period. As shown in Exhibit 5, the greatest increases in housing are predicted in Medway, Dartford and Maidstone and will place pressure on health and social care services, such as maternity and children’s services.

Exhibit 5 – Planned housing developments

3.2 Local people are living longer and older people tend to have additional health needs

As shown in Exhibit 6, older people (aged 75+) are the fastest growing group of people in Kent and Medway with total growth in the number of over 65s being more than four times greater than those
under 65. That people now live for longer than they have ever done before is definitely a cause for celebration. However, a growing ageing population also brings with it specific health needs that need to be accounted for. Older people are more likely to develop long-term health conditions such as diabetes, heart disease and breathing difficulties, and are more at risk of strokes, cancer and other health problems – together this means that people tend to need more care and more treatment as they get older. Indeed, within Kent and Medway the gap between healthy life expectancy and life expectancy can be as much as 22 years presenting a challenge in terms how we can best manage the elderly population so that we can improve their quality of life.

Exhibit 6 – Growth in numbers of people in Kent and Medway and England

<table>
<thead>
<tr>
<th>2016 population</th>
<th>Demographic growth rates over the next 5 and 10 years</th>
<th>Additional people in 5 years</th>
<th>Additional people in 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.9K 90 and over</td>
<td>25% 34% Total = 59%</td>
<td>4.5K</td>
<td>10.6K</td>
</tr>
<tr>
<td>30.0K 85-89</td>
<td>14% 18% Total = 32%</td>
<td>4.1K</td>
<td>9.5K</td>
</tr>
<tr>
<td>109.1K 75-84</td>
<td>19% 28% Total = 47%</td>
<td>21.0K</td>
<td>51.4K</td>
</tr>
<tr>
<td>194K 65-74</td>
<td>3% 2% Total = 5%</td>
<td>6.5K</td>
<td>20.4K</td>
</tr>
<tr>
<td>1,126.8K 14-65</td>
<td>2% Total = 4%</td>
<td>24.1K</td>
<td>50K</td>
</tr>
<tr>
<td>328.4K 0-14</td>
<td>2% Total = 8%</td>
<td>18.7K</td>
<td>25.3K</td>
</tr>
<tr>
<td>1,806.2K</td>
<td></td>
<td>79.1K</td>
<td>167.2K</td>
</tr>
</tbody>
</table>

Notes: This excludes additional people as a result of planned housing developments
Source: Office for National Statistics 2016

An ageing population also means increasing numbers of people with dementia – there are around 12,000 people in Kent and Medway with dementia – and many more who do not have a formal diagnosis. Older people will also find it more difficult to access services (especially if they have to travel long distances) and may also be carers for another older person in poor health.

Altogether, the variety of health and social care needs presented by Kent and Medway’s elderly population calls for a more integrated approach so that we can enhance how services and improve their outcomes. Evidence shows that compared to other age groups, older people are more dependent users of healthcare, particularly in relation to hospital admissions and the use of community services. If nothing changes, it is estimated that an extra 773 hospital beds would be needed by 2021 just to meet the requirements of the growing, aging population. The solution to this involves various stakeholders across health and social care coming together to create a more incorporated system of service delivery, one that puts prevention and self-management at the centre and also ensures that care can be delivered at home rather than in a ward.

Ultimately, the cost implications associated with meeting the needs of the older population will mean that existing systems of managing demand will prove unsustainable. People aged 70+ make up
the largest proportion of those with dementia, physical disabilities and cancer in Kent and Medway, which are all expensive services to run. For example, as shown in Exhibit 7, 92% of people with dementia in Kent and Medway are over the age of 70 and require an average £71m per year in health and social care\textsuperscript{24}.

Exhibit 7 – Cost of services for older population

<table>
<thead>
<tr>
<th>Proportion of patients aged 70+</th>
<th>Cost per head (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia</td>
<td>92%</td>
</tr>
<tr>
<td>Physical disabilities</td>
<td>77%</td>
</tr>
<tr>
<td>Cancer</td>
<td>51%</td>
</tr>
<tr>
<td>Chronic conditions</td>
<td>26%</td>
</tr>
<tr>
<td>SEMI\textsuperscript{1}</td>
<td>13%</td>
</tr>
<tr>
<td>Mostly healthy</td>
<td>6%</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>6%</td>
</tr>
</tbody>
</table>

Note: \textsuperscript{1} SEMI refers to Serious and Enduring Mental Illness
\textsuperscript{2} Patient level data has been used to calculate disease prevalence for each age group, however, the proportion of elderly patients in the SEMI and learning disabilities categories may be artificially high due to poor data quality and errors in coding. It has not been possible to validate the extent to which this may be an issue.

Source: CCG 14/15 spend by POD, Monitor Ready Reckoner Tool, Carnall Farrar analysis

3.3 There are widespread inequalities across Kent and Medway

There is a wide spread of deprivation across Kent and Medway, which comprises some of the most affluent and the least affluent districts in England. Deprivation across Kent and Medway is shown in Exhibit 8 – this shows deprivation at the level of local authority and it is important to note that when viewed at a more local level, high deprivation is present across Kent and Medway\textsuperscript{25}. 
Poverty and deprivation are key causes of poor health outcomes. Higher levels of deprivation are linked to many health problems, such as prevalence of long-term health conditions. As a result, deprivation is linked to poorer health outcomes, such as a lower life expectancy, as shown in Exhibit 9. We can also see significant variation between healthy life expectancy and life expectancy, with the difference being as much as 22 years for women in Medway. This represents 22 years of ill health, where problems that are associated with getting older such as arthritis and dementia start to present themselves. These statistics are very much in line with some of the worst areas in London and shows that more can be done to reduce the gap and improve the quality of life of those who are getting older.
Health risk behaviours such as smoking, alcohol consumption, physical inactivity, poor diet and being overweight cause poor health, worsening of disease, multiple illnesses and early death\textsuperscript{27}. As shown in Exhibit 10, the most deprived areas of Kent and Medway have higher levels of obesity\textsuperscript{28}, more children living in poverty\textsuperscript{29} and more people who smoke\textsuperscript{30}. Screening levels for diseases such as breast cancer are also lower\textsuperscript{31}. Importantly, lifestyle and clinical risk factors tend to cluster in the same individuals and groups of people; for example, Thanet has the 4th highest rate of mortality from liver disease (considered preventable) in the South East and is one of the most deprived areas of the country\textsuperscript{32}. Although mortality rates overall are falling, the gap in mortality between the most and least deprived areas in Kent and Medway has persisted for years\textsuperscript{33}.

### Exhibit 9 – Difference in life expectancy across Kent and Medway

<table>
<thead>
<tr>
<th></th>
<th>LE</th>
<th>HLE</th>
<th>Difference</th>
<th>LE</th>
<th>HLE</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent</td>
<td>80</td>
<td>64</td>
<td>16</td>
<td>84</td>
<td>64</td>
<td>20</td>
</tr>
<tr>
<td>Medway</td>
<td>78</td>
<td>62</td>
<td>17</td>
<td>82</td>
<td>60</td>
<td>22</td>
</tr>
<tr>
<td>England</td>
<td>80</td>
<td>63</td>
<td>16</td>
<td>83</td>
<td>64</td>
<td>19</td>
</tr>
</tbody>
</table>

Source: Index of Multiple Deprivation 2015 (by local authority); Office for National Statistics 2015
Exhibit 10 – People in more deprived communities are more likely to experience poor health and less likely to use preventative services

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Kent</th>
<th>Tunbridge Wells</th>
<th>Tonbridge &amp; Malling</th>
<th>Sevenoaks</th>
<th>Maidstone</th>
<th>Canterbury</th>
<th>Ashford</th>
<th>Dartford</th>
<th>Dover</th>
<th>Gravesham</th>
<th>Medway</th>
<th>Shepway</th>
<th>Swale</th>
<th>Thanet</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excess weight in 4-5 year olds</td>
<td>21</td>
<td>21</td>
<td>21</td>
<td>20</td>
<td>24</td>
<td>26</td>
<td>25</td>
<td>23</td>
<td>22</td>
<td>24</td>
<td>23</td>
<td>25</td>
<td>22</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Excess weight in 10-11 year olds</td>
<td>30</td>
<td>29</td>
<td>28</td>
<td>32</td>
<td>33</td>
<td>34</td>
<td>34</td>
<td>34</td>
<td>35</td>
<td>35</td>
<td>35</td>
<td>35</td>
<td>34</td>
<td>34</td>
<td>35</td>
</tr>
<tr>
<td>Children in poverty (2013)</td>
<td>10</td>
<td>12</td>
<td>12</td>
<td>14</td>
<td>17</td>
<td>16</td>
<td>15</td>
<td>21</td>
<td>20</td>
<td>21</td>
<td>20</td>
<td>23</td>
<td>26</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Low birth weight at full term</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Breastfeeding initiation at 48hrs (2012-14)</td>
<td>85</td>
<td>77</td>
<td>N/A</td>
<td>76</td>
<td>75</td>
<td>67</td>
<td>N/A</td>
<td>N/A</td>
<td>69</td>
<td>71</td>
<td>64</td>
<td>67</td>
<td>74</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Infant mortality rate/1000 live births</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

3.4 People are living in poor health with preventable long-term conditions

A long-term condition is a health problem that is present for over a year. There are 528,000 people (including 19,000 children) in Kent and Medway with one or more significant long-term condition. There are high levels of obesity, depression, diabetes (in adults) and asthma, and very high levels of hypertension (high blood pressure) compared to the national average and other similar places. On average, a person with a long-term condition requires six times more health and social care support as a generally healthy person.

Exhibit 11 shows the prevalence of different diseases within Kent and Medway. We can see that variances against the national median are minimal and that the three biggest health issues include hypertension, obesity and depression, again reflecting much of the UK. If left untreated (or even unrecognised), these issues can worsen and lead to other health problems such as stroke and cancer. The prevalence of different diseases should act as signals in helping decide the type of service that is most useful and that addresses the needs of the Kent and Medway population. It is also helpful in informing prevention strategies and how we can target particular issues. Steps are being taken to do this and we can see in Medway for example, local organisations coming together to talk about how best to tackle the biggest issues such as obesity and weight-related health problems. However, more can be done, particularly in raising awareness of the severity of these issues and how self-management can play an important part in reducing symptoms and improving outcomes.
As the population gets even older, more people are likely to have a long-term condition. This is a challenge for health and social care services because people with one or more long-term condition need high quality, consistent and integrated health and social care. People with a long-term condition are also likely to have a long-term informal carer (such as a spouse or grown-up child) and these carers also need to be supported.

3.5 There are differing levels of health and social care needs

One way of understanding the needs of local people is to break down the population into different groups. This can be done by grouping people of a similar age and with similar health needs. The analysis can then be used to identify how work across health and social care can achieve a greater impact, and estimate the potential benefits that can be achieved through interventions targeting particular groups.

Exhibit 12 shows that there are around 1.3m people (71% of the population) in Kent and Medway who are mostly healthy and use an estimated 29% of health and social care. However, there are around 528,000 (29%) people with one or more significant long-term condition, who use an estimated £1.7bn (71%) of health and social care; the estimated 167,000 older people with long-term conditions are particularly high users of health and social care (c. £5k per person per annum).

There are an estimated 11,000 people in Kent and Medway with a SEMI (severe and enduring mental illness) who are individually very high cost (for example, c. £9k per person per year for those over 70), as are those with learning disabilities and severe physical difficulties; an estimated £182m is spent on approximately 12,000 adults with a physical or learning disability in Kent and Medway (c. £18k per person per year). Reported dementia affects an estimated 12,000 people, with an estimated spend of around £79m per year spent on this group (an average of nearly £7k per person
per year). There are also around 48,000 people with cancer, costing an estimated £162m per year in total.

The calculation used to generate these figures is shown in more detail in Appendix 1.

Exhibit 12 – Kent and Medway health and care segmentation, 2015-16

<table>
<thead>
<tr>
<th>Total spend across Kent &amp; Medway 2016/15 (£m)</th>
<th>Population (k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly Healthy</td>
<td>666m</td>
</tr>
<tr>
<td>Other chronic conditions</td>
<td>741m</td>
</tr>
<tr>
<td>Physical disability</td>
<td>465m</td>
</tr>
<tr>
<td>Cancer</td>
<td>162m</td>
</tr>
<tr>
<td>Learning disability</td>
<td>118m</td>
</tr>
<tr>
<td>SEMI</td>
<td>105m</td>
</tr>
<tr>
<td>Dementia</td>
<td>79m</td>
</tr>
<tr>
<td>Children (0-15 yrs)</td>
<td>1,313k</td>
</tr>
<tr>
<td>Adults (16-69 yrs)</td>
<td>422k</td>
</tr>
<tr>
<td>Elderly (70+ yrs)</td>
<td>29k</td>
</tr>
</tbody>
</table>

Note: 1. “Other chronic conditions” include asthma, coronary heart disease, chronic kidney disease, chronic obstructive pulmonary disease, depression, diabetes, epilepsy, heart failure, hypertension, stroke. 2. Spend on children with physical disability has been excluded due to lack of data.

Source: Kent Integrated Dataset; Financial data provided by all Kent and Medway CCGs, NHS England, Kent County Council, Medway Council (October 2016); Carnall Farrar analysis

Exhibit 13 shows the same information in a different format. It shows that, in Kent and Medway, around 29% of local people use 75% of health and social care.
This suggests that the priority groups for focus are people with mental illness and people at risk of poor mental or physical health. It is also important to make sure high-quality services are available when required for the majority of local people who are not high users of services.

3.6 Many people have poor mental health, often alongside poor physical health

Mental illness is relatively common in Kent and Medway with around 163,500 local people aged 18-64 having a common mental disorder such as depression or anxiety\(^{38}\) and some 6,600 people having a more serious mental health illness such as schizophrenia\(^{39}\). These figures are broadly in line with the rest of England and emphasises the importance of addressing mental health when it comes to delivering an effective health service that meets the needs of its population. As the World Health Organisation puts it, ‘there is no health without mental health’\(^{40}\).

It is also important to note that mental health problems disproportionately affect people living in the most deprived areas, as shown in Exhibit 14. Whilst deprivation may not necessarily show a cause, there is a clear correlation between living in an area of high deprivation and the likelihood of developing a serious mental health disorder in the future. Studies have attributed this to the fact that deprivation in itself triggers chronic low-level stress as people try to ‘cope’ with the disadvantages associated with living in deprived conditions (such as low income and a lack of education)\(^{41}\). Indeed, these factors can also lead to poor physical health as people with mental health conditions are more likely than the general population to lead a lifestyle that contributes to negative health outcomes. For example, almost 50% of adults with severe mental illness are smokers, compared to 25% in people without a severe mental illness\(^{42}\).
Exhibit 14 also shows that mental ill health affects children and young people. Approximately 10% of the population in Kent and Medway aged from 5 to 16 has a diagnosable mental health problem (which is similar to the national average). However, much like the rest of the population, children from low income families and those living in deprivation are at highest risk of having poor mental health. Kent and Medway in particular contains a large number of children who are living in deprived households. Over 59,000 children are in low income families, making up 17% of all those aged under 16, the national average is just under 20%.

Mental illness is prevalent, contains multiple co-occurring conditions, links to physical illness and results in early mortality and considerable loss of functioning for the individuals affected. Data from Kent County Council and Medway Council shows that:

- In Kent there were 461 suicides during 2014-16, with 352 of these being male. Suicide rates in Kent are 11.6 per 100,000 population, which is statistically significantly higher than the national rate of 9.9 per 100,000.

- In Medway, there were 79 suicides during 2014-16, with 63 of these being male. Overall, this equates to a rate of 11.1 suicides per 100,000 population. This is also higher to the national rate of 9.9 per 100,000, although is statistically similar.

- Self-harm rates have risen since 2007 to 2017. In Kent, there was an estimated 5,920 people with a hospital admission for self-harm. In Medway, there were 577 emergency hospital admissions for intentional self-harm.

- There are an estimated 163,500 people across Kent and Medway aged over 16 who have a treatable common mental illness (depression and or anxiety). This is 12.9% of the population.
(an increase of 0.8% from 2007, most of which have been found in men).

- There are an estimated 4,624 people in Kent with serious mental illness. In Medway, there are 1,984 people registered with their GP as having a severe mental illness.

- Compared with mental health problems alone, people with dual diagnosis often experience more severe mental health problems with increased risk of homelessness and suicide.

- Nationally, 41% of suicides are attributable to alcohol, in Kent and Medway there is a substantial treatment gap for dual diagnosis.

Ultimately, the consequences of poor mental health can result in a mortality gap of around 10 to 20 years depending on the severity of the condition\textsuperscript{46}. People with Severe Mental Health disorders have lower life expectancies than those without mental illness with the main cause of premature death being cancer, COPD and heart disease\textsuperscript{47}. These stark differences in life expectancy are unacceptable and need to be addressed urgently.
4. The case for change in services for children and young people

The importance of health and wellbeing in early childhood and adolescence cannot be stressed enough – it is a significant determinant of physical and emotional wellbeing all the way through to adulthood. In this Case for Change, we will examine the performance of the local health and care system in Kent and Medway across a number of core indicators affecting children and young people and will identify where improvements can be made.

Children and young people under the age of 20 make up a quarter of the population in both Kent and Medway. The key issues facing them include:

- **Good maternal health is important to ensure babies have the best start.** In Kent and Medway, **there is a high number of mothers who smoke during their pregnancy** (13.8% in Kent and 17.1% in Medway). This is higher than the national average and can lead to increased risk of developing placenta problems and premature birth. As well as this, over half of mothers are overweight or obese which can increase the risk of stillbirth.

- **Children in their early years do not have adequate vaccination coverage** for measles, mumps and rubella (MMR), Meningitis C and pneumococcal infections. This can lead to increased risk of spreading infectious disease, disability and death. A minimum of 90% of the local population need to have been vaccinated to create ‘herd immunity’ to prevent outbreaks spreading and neither Kent or Medway are meeting this standard.

- **1 in 5 primary school children are obese or overweight** which can have implications in adulthood if not addressed (such as developing diabetes and premature death). There is also high absenteeism across Kent and Medway. Just under 10% of primary school children miss what equates to a month of the academic year. Poor attendance at school affects educational development and is linked to youth crime, substance misuse and teenage pregnancy.

- **The rate of teenage pregnancies is above the regional average in Kent and Medway.** Babies born to teenage mothers are of higher risk of dying and are usually born into poorer socioeconomic conditions due to the impact teenage pregnancy has on the mother’s education and employment.

- **Around 10% of children and young people have a mental health issue and there is a particular concern for looked after children.** In Kent and Medway, just under half of all looked after children are at a higher risk of developing a mental health disorder. There is also low educational attainment - only 10% of looked after children in Kent for example gained 5 GCSEs at A*- C including English and Maths. Low educational attainment is linked to poorer health outcomes in adulthood.

- **12% of children in Kent and 17% of children in Medway have a special educational need.** Identifying how their needs change as they grow is important to ensure the best outcomes for them into adulthood and that there is a quality of care available.

- **There is minimal local provision of cancer care for children.** Around 98% of all inpatient activity relating to cancer for people aged 0 to 19 occurs in hospitals outside of Kent and Medway. As well as this, there is a lack of coordination with the hospitals delivering this care (such as Great Ormond Street Hospital and The Royal Marsden Hospital).
- Patient experiences in paediatric services are inconsistent across Kent and Medway and reflects the fact that a number of clinical standards are not being met. Only one out of the four trusts in Kent and Medway meet more than 90% of relevant clinical standards. Different factors influence the issues above however it is clear that wider social determinants such as deprivation play an important role in affecting wellbeing outcomes for children. Indeed, within Kent and Medway the level of child poverty is worse than the national average with around 1 in 5 children aged under 16 living in poverty. The most deprived areas of Kent and Medway have higher levels of childhood obesity, more children living in poverty and more children with mental health issues (as shown in Exhibit 15).

Exhibit 15 – Deprivation affects the health and wellbeing of children in Kent and Medway

Despite these challenges however, the current life expectancy at birth for children in Kent and Medway is 79.8 and 78.4 years respectively for males and 83.5 and 82 years respectively for females – in line with much of the rest of the country.

Pregnancy and birth

Supporting good maternal health is crucial to ensure babies have the best start in life. This includes reducing the number of women who smoke or consume alcohol during their pregnancy or whose nutrition is insufficient – all of which can lead to negative outcomes for the baby.

Among the spectrum of key indicators listed by Public Health England under ‘pregnancy and birth’, Kent and Medway are achieving better or as good as the national average when it comes to such things as birthweight, conception rates for those aged under 16, rate of stillbirths and infant mortality. However, there are number of key areas which still need further improvement as shown in Exhibit 16.
Within Kent, 13.8% of women smoke whilst pregnant, which is higher than the national average. In Medway, this figure is even greater at 17.1%. There is growing evidence that a child born to a mother who smokes is twice as likely to be delivered prematurely, more likely to suffer from placenta problems around the time of birth and more likely to be a victim of cot death. Significant achievements have been made to reduce the number of overall smokers within Kent and Medway, with 1 in 5 quitting in the first six months of 2017 alone. However, it is clear that more targeted strategies are now necessary, particularly for pregnant women.

Breastfeeding initiation is also a key benchmark where both Kent and Medway are performing badly. The percentage of mothers who breastfeed their baby in the first 48 hours after delivery is below both the national and regional average and this gap has widened in recent years. Delayed breastfeeding initiation has also been shown to increase the risk of neonatal mortality by as much as twofold. There is a strong argument to increase awareness of the benefits associated with early breastfeeding to ensure better outcomes for the mother and child and the continuation of breastfeeding.

Lastly, being overweight or obese during pregnancy can result in negative outcomes for the mother and the baby, including gestational diabetes and preeclampsia. Within Kent and Medway, around half of all mothers were recorded as overweight or obese during a routine appointment whilst pregnant (as shown in Exhibit 17). As well as harmful effects to the mother, maternal obesity can also increase the risk for stillbirth and congenital anomalies and increases the likelihood that the child will grow up to become obese themselves. Complications during the delivery are also more common, resulting in longer length of stays in the hospital.
In view of all the issues highlighted above, we can see that there is a strong argument for changing how preconception and pregnancy services are delivered in Kent and Medway so that they are of high quality and meet the specific needs of the population. Health visits are one such method of putting this into action, particularly after birth, ensuring that a tailored and effective care plan is in place to maximise the baby’s chances of staying healthy and gaining the best start to life. Evidence shows that home visits by health professionals in the weeks following birth can help improve the mother’s mental health and tackle postnatal depression⁵⁷. Within Kent, 76.3% of babies received a six to eight week review by a health visitor before they turned eight weeks and in Medway it was 75.8%. This is below the national average of 80.4% and the regional average of 83.7% - suggesting that improvements can be made.

**Early years**

For children aged 0-5, Kent and Medway perform better than the national average in areas such as the number of A&E attendances, admissions for respiratory tract infections and overall dental health⁵⁸. However, Exhibit 18 shows that vaccination coverage is an area where improvements can be made:
Population vaccination coverage is a key concern. The percentage of eligible children who have received two doses of the MMR vaccine on or after their first birthday and anytime up to their fifth birthday is below the national benchmark as well as the targeted benchmark of 95% as advised by Public Health England. Coverage for booster vaccinations to protect against Meningitis C and pneumonia are also below national standards. This is concerning, especially when considering that only three years ago, both Kent and Medway were performing above or meeting national standards. Some vaccines do not work effectively with just a single dose hence why a booster is needed – it is therefore crucial for clinics to monitor missed and partly vaccinated children and assess and address the causes. The consequences of not vaccinating children from diseases such as measles and meningitis include brain damage, disability and premature death.

Primary school aged children

As children reach primary school age (5-11), Kent and Medway perform reasonably well against the national and regional benchmarks on key indicators such as key stage 1 pupils meeting expected standards in reading writing and maths and overall dental health.

However, as we have seen previously, there are a number of areas for improvement that have long term effects on health if left ignored. In Kent for example, 23% of children in reception are classified as overweight or obese and in Medway it is 21.8%. Both areas are above the regional average of 20.9%. The implications of this include a higher chance of disability and premature death in adulthood, developing diabetes and cardiovascular diseases as well as increasing the likelihood of some types of cancer such as breast and colon.

There are also a number of school-based indicators of concern within Kent and Medway (as shown in Exhibit 19). Around 9 to 10% of primary school children are defined as being ‘persistently absent’ from school (missing what equates to a month of the academic year). This is worse than the national average of just over 8%. The percentage of primary school children who have received a fixed period exclusion is also above national average (3 times higher in the case of Medway). This all impacts on...
the child’s educational development and there is clear evidence of a link between poor attendance at school and low levels of achievement\textsuperscript{62} – in Medway for example, only 48.6\% of Key Stage 2 pupils in primary school meet the expected standard in reading, writing and maths.

**Exhibit 19 – Primary school age indicators**

<table>
<thead>
<tr>
<th>% of persistent absenteees in state funded primary schools</th>
<th>Year</th>
<th>Kent</th>
<th>Medway</th>
<th>South East average</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of persistent absenteees in state funded primary schools</td>
<td>2015/16</td>
<td>8.7</td>
<td>9.9</td>
<td>7.7</td>
<td>8.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of primary school pupils who received a fixed period exclusion</th>
<th>Year</th>
<th>Kent</th>
<th>Medway</th>
<th>South East average</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of primary school pupils who received a fixed period exclusion</td>
<td>2014/15</td>
<td>1.26</td>
<td>3.65</td>
<td>1.34</td>
<td>1.10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of Key Stage 2 pupils meeting the expected standard in reading, writing and maths</th>
<th>Year</th>
<th>Kent</th>
<th>Medway</th>
<th>South East average</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Key Stage 2 pupils meeting the expected standard in reading, writing and maths</td>
<td>2016</td>
<td>58.6</td>
<td>48.6</td>
<td>55.4</td>
<td>53.8</td>
</tr>
</tbody>
</table>


**Secondary school aged young people**

This pattern of high absenteeism seen in primary school continues into secondary school. In both Kent and Medway, just over 14\% of secondary school pupils are defined as being persistently absent. This is above the national and regional benchmark and is significant when considering the correlation poor attendance has on lack of educational achievement and ultimately future health outcomes. Evidence shows that the less education adults have, the more likely they are to smoke, be overweight, have diabetes and die prematurely\textsuperscript{63}.

**Exhibit 20 – Secondary school age indicators**

<table>
<thead>
<tr>
<th>% of persistent absenteees in state funded secondary schools</th>
<th>Year</th>
<th>Kent</th>
<th>Medway</th>
<th>South East average</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of persistent absenteees in state funded secondary schools</td>
<td>2015/16</td>
<td>14.2</td>
<td>14.1</td>
<td>13.2</td>
<td>13.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of secondary school pupils who were bullied in the past couple of months</th>
<th>Year</th>
<th>Kent</th>
<th>Medway</th>
<th>South East average</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of secondary school pupils who were bullied in the past couple of months</td>
<td>2014/15</td>
<td>59.5</td>
<td>57.1</td>
<td>57.3</td>
<td>55.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of 16-18 year olds not in education, employment or training</th>
<th>Year</th>
<th>Kent</th>
<th>Medway</th>
<th>South East average</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of 16-18 year olds not in education, employment or training</td>
<td>2015</td>
<td>5.0</td>
<td>7.4</td>
<td>3.9</td>
<td>4.2</td>
</tr>
</tbody>
</table>


Bullying has been shown to be a contributing factor leading to increased absenteeism\textsuperscript{64} and in both Kent and Medway, just under 60\% of all pupils aged 15 years said they were being bullied at school.
This is above the national benchmark and is of particular concern when considering how bullying can negatively impact a student’s physical, emotional and mental wellbeing and lead to riskier behaviours such as alcohol or substance abuse\textsuperscript{65}. The impact on educational achievement can be clearly observed in Kent and Medway where 5 to 7\% of the population of 16-18 year olds are defined as not being in education, employment or training. This is notably worse than the national and regional averages.

Teenage pregnancy is also an issue for secondary school aged young people. Both Kent County Council and Medway Council have strategies for dealing with teenage pregnancy. This Case for Change sets out existing performance, its implications and supports the case for further action.

\textit{Exhibit 21 – Teenage pregnancy in Kent and Medway}

As we can see above in Exhibit 21, both Kent and Medway perform comparatively worse against the regional average when it comes to the number of under 18 conceptions, with Medway performing adversely against the national benchmark as well. Whilst significant progress has been made to reduce the number of under 18 conceptions in both areas, more can be done. Data shows babies born to adolescent mothers face a substantially higher risk of dying than those born to women aged 20 to 24\textsuperscript{66}. Teenage motherhood can also have a negative social and economic effect with young mothers most often having to drop out of school, leading to fewer skills and opportunities to find a job.

Another area of concern is hospital admissions. The number of young people in Kent and Medway who are being admitted into hospital due to symptoms related to diabetes is more than 19\% above the national average, indicating that not enough is being done to prevent and manage this condition. More concerning is that this gap has widened for two consecutive years with little or no sign of
improvement (as shown in Exhibit 22). The repercussions of not managing diabetes can include kidney damage, limb amputations and stroke.

**Exhibit 22 – Hospital admissions for young people: diabetes**

The number of hospital admissions relating to diabetes in young people has historically been above the national average in Kent and Medway.

<table>
<thead>
<tr>
<th>Year</th>
<th>Kent</th>
<th>Medway</th>
<th>South East average</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>103.9</td>
<td>121.9</td>
<td>85.9</td>
<td>86.8</td>
</tr>
</tbody>
</table>

We can also see below in Exhibit 23 that the number of hospital admissions relating to substance misuse (such as drugs and alcohol) in Kent is 13% higher than the national benchmark and 26% higher than the regional benchmark. This trend has existed since 2011 with very little sign of improvement. Medway on the other hand is better than the national and regional averages.

Substance misuse has enormous implications on the health service – heavy alcohol drinking alone can lead to long term liver damage\(^ \text{67} \) and mental health problems\(^ \text{68} \), and drug abuse is closely associated with increased risk of cardiovascular disease\(^ \text{69} \) and respiratory problems\(^ \text{70} \). Studies show that adolescent substance misuse is common due to the presence of certain risk factors, such as deprivation, academic failure and peer pressure\(^ \text{71} \).
Children and young people’s mental health

The mental health of all children is important. With half of adult mental health problems starting before the age of 14, early intervention to support children and young people with mental health and emotional wellbeing issues is very important\(^\text{72}\). Positive emotional wellbeing is fundamental to improved physical and cognitive development, better relationships with family members and peers and a smoother transition into adulthood\(^\text{73}\).

Identifying mental health issues starts at preconception and during pregnancy. The social and emotional wellbeing of a baby or toddler can be affected by whether the mother has a mental health problem herself\(^\text{74}\). Evidence shows that failure to treat postnatal depression promptly may result in a prolonged, harmful effect on the relationship between the mother and baby and on the child’s psychological, social and educational development\(^\text{75}\). It is believed that overall between 10% and 20% of women are affected by mental health problems at some point during pregnancy or the first year after childbirth\(^\text{76}\).

In Kent and Medway, around 20,200 babies were born in 2015. Of the women who gave birth:

- 40 had postpartum psychosis
- 40 had a serious mental illness
- 610 had a severe depressive illness
- 610 has post-traumatic stress disorder
- 3,035 had a depressive illness and anxiety; and
- 6,060 had an adjustment disorder and distress
These figures represent more than half of all mothers. Other risk factors are also associated with increasing the likelihood of young children in their early years of developing a mental health condition. These include:

- **Domestic violence and abuse**: Living in a household where domestic violence is occurring can impact a child’s mental, emotional and psychological health and their social and educational development. In 2015 there were 23.1 domestic abuse incidents per 1,000 population reported to the police force area which covers Kent and Medway, compared to 22.1 per 1,000 nationally.

- **Poor social support**: Women who lack social support have been found to be at increased risk of antenatal and postnatal depression. In Kent, 5.3% of births were registered by just one parent which is similar to the average of 5.4%. In Medway, this figure is slightly higher at 6%.

- **Drug and alcohol misuse**: If a parent or caregiver misuses alcohol or drugs, there can be an impact on a baby or toddler’s development, often due to parenting problems. As the NSPCC ‘Spotlight on Drugs and Alcohol’ report states, “parents misusing substances are at risk of a wide range of difficulties associated with their role as a parent. These may include a lack of understanding about child development issues, ambivalent feelings about having and keeping children and lower capacities to reflect on their children’s emotional and cognitive experience.” At 3-4 years of age, parental problem drug use can continue to jeopardise the child’s development in a number of ways such as being left unsupervised or neglected, physical violence or emotional abuse and less time stimulated through play or reading. The figures below show that in Kent and Medway the number of parents in drug and alcohol treatment is above the regional benchmark.

### Exhibit 24 – Parents in drug and alcohol treatment

<table>
<thead>
<tr>
<th>Parents in drug treatment, rate per 100,000 children aged 0-15</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent</td>
<td>106.8</td>
</tr>
<tr>
<td>Medway</td>
<td>115.9</td>
</tr>
<tr>
<td>South East</td>
<td>78.8</td>
</tr>
<tr>
<td>England</td>
<td>110.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parents in alcohol treatment, rate per 100,000 children aged 0-15</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent</td>
<td>120.5</td>
</tr>
<tr>
<td>Medway</td>
<td>Suppressed</td>
</tr>
<tr>
<td>South East</td>
<td>120.0</td>
</tr>
<tr>
<td>England</td>
<td>147.2</td>
</tr>
</tbody>
</table>


With these risk factors in mind, Exhibit 25 below shows the prevalence of mental health and emotional disorders in children in Kent and Medway compared to the national and regional benchmarks.
Exhibit 25 – Prevalence of mental health and emotional disorders in Kent and Medway in 2015

Exhibit 26 – School-based mental health indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>England</th>
<th>South East</th>
<th>Kent</th>
<th>Medway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pupils with social, emotional and mental health needs (Primary school age)</td>
<td>2016</td>
<td>2.36</td>
<td>2.39</td>
<td>2.23</td>
<td>3.52</td>
</tr>
<tr>
<td>Pupils with social, emotional and mental health needs (Secondary school age)</td>
<td>2016</td>
<td>2.34</td>
<td>2.37</td>
<td>2.38</td>
<td>3.38</td>
</tr>
</tbody>
</table>

Key: Lower Similar Higher than the national benchmark


Medway in particular has a higher percentage of pupils in primary and secondary school who have social, emotional and mental health needs above the national and regional benchmarks (as shown below):

The mental wellbeing in 15 year olds was also recorded as part of a nationwide Department of Health commissioned survey into the healthy behaviours of adolescents. Two of the key indicators extracted from the feedback received from this survey are shown below:
Exhibit 27 – Mental wellbeing of 15 year olds

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>England</th>
<th>South East</th>
<th>Kent</th>
<th>Medway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive satisfaction with life among 15 year olds: % reporting positive life satisfaction</td>
<td>2014/15</td>
<td>63.8</td>
<td>63.3</td>
<td>63.9</td>
<td>59.9</td>
</tr>
<tr>
<td>Mental Wellbeing in 15 year olds: Mean wellbeing (WEMWBS-14) score</td>
<td>2014/15</td>
<td>47.6</td>
<td>47.5</td>
<td>47.6</td>
<td>46.5</td>
</tr>
</tbody>
</table>


As before, we can see a greater problem in Medway where just under 60% of 15 year olds responded that they had positive life satisfaction (below the national and regional benchmark). The second indicator shown above is the mean WEMWBS score which is derived from the Warwick-Edinburgh Mental Wellbeing questionnaire that measures mental wellbeing. A score between 40 and 59 signifies that the respondent’s wellbeing is average and that they can improve their mental health by taking action\(^81\). The mean score in Medway is below the national and regional benchmark, indicating that more can be done to improve mental health within 15 year olds.

Poor mental health within in children and young people can have considerable implications for physical health. Mental ill health is associated with higher rates of smoking, alcohol, drug abuse, lower educational outcomes, reduced employment prospects and weaker social relationships – all of which leave lead to an increased risk of developing a physical health problem and greater pressures on the health system. As the King Fund states, “for most people, mental health problems begin in childhood or adolescence. This can have lifelong effects, and is a major route through which health and social inequalities are transmitted across generations”\(^82\). There is a clear need to improve child and adolescent mental health services and to ensure early identification of emotional problems in childhood so that the longer-term impacts on the health service are reduced.

Looked after children

A child is looked after by a local authority if a court has granted a care order to place the child in care, or a council’s children’s services department has cared for the child for more than 24 hours. In Kent the number of looked after children and young people in 2017 was 1,900 and in Medway it was 390. This represents 57 out of every 10,000 0-17 year olds in Kent and 61 out of every 10,000 0-17 year olds in Medway (both above the regional average).
Both Kent and Medway councils have a detailed approach in delivering care and support services for these looked after children. In the context of this Case for Change, we can see in Exhibit 29 that the health and wellbeing of looked after children in Kent and Medway is mixed when comparing nationally. For example, the number of looked after children with up to date immunisations is below the national average in Kent but better than the national average in Medway.

As we have discussed earlier, the emotional wellbeing and mental health of children and young people in Kent and Medway is a key priority. The cross-government mental health strategy, ‘No Health without Mental Health’, identifies looked after children as one of the particularly vulnerable groups at risk of developing mental health problems. Exhibit 29 shows the number of looked after children who are defined as being a ‘cause for concern’. This is measured through a behavioural screening questionnaire where participants are asked to provide feedback on how they would
respond in particular situations. The higher the score given the higher the risk of mental ill health\textsuperscript{83}. A total difficulties score of 17 or higher is defined as being a ‘cause for concern’ and indicates significantly poor emotional wellbeing. Within Kent, 41.6\% of looked after children who have been in care for at least 12 months scored 17 or higher, and in Medway this figure is 47.6\%. This is above both the national and regional benchmarks. This means that in Kent and Medway, looked after children are more at risk of developing a mental health problem (which in itself has implications on the local health system) and poor mental health has also been shown to negatively impact physical health and lead to increased risk of heart disease and cancer in adulthood\textsuperscript{84}.

Lastly, school achievement is considerably poorer when compared to children who are not in care. Around 59\% of all children in Kent and Medway gained 5 GCSEs at A*- C including English and Maths. However, out of all looked after children, only 10\% in Kent and 29\% in Medway gained the same results. Although some do well, looked after children as a group have poor experiences of education and very low educational attainment. The reasons for this include spending too much time outside of school, insufficient help when their education falls behind, and primary carers not equipped to provide adequate support and encouragement for learning and development. As discussed earlier, low educational attainment is often associated with poorer health outcomes into adulthood, this can result in increased use of the health system and pressure on services.

**Special educational needs**

Special educational needs (SEN) is a legal term that describes the needs of a child who has a difficulty or disability which makes learning harder for them than for other children their age. This includes children with Autism Spectrum Disorder (ASD) including Asperger’s syndrome or childhood autism; and Attention Deficit Hyperactivity Disorder (ADHD).

Whilst it is recognised that it is difficult to accurately record the numbers of disabled children living in any authority, the Department of Education provides statistics on the number of children enrolled in school who are defined as having a special educational need (as shown below):

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>England</th>
<th>South East</th>
<th>Kent</th>
<th>Medway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of pupils with SEN (%)</td>
<td>2017</td>
<td>14.0</td>
<td>14.1</td>
<td>12.3</td>
<td>16.5</td>
</tr>
</tbody>
</table>


As we can see, Medway has a higher proportion of school aged children with a special educational need. When breaking this into the type of need presented we can see in Exhibit 31 that during primary school years, speech and communicational needs are the most commonly presented issue. During secondary school however, social, emotional and mental health needs predominate. The implications of this mean that from childhood to adulthood, the type of care required for those with a learning disability will need to change.
When looking at children with special educational needs it is undeniable that integration is a vital component of an effective care plan that meets the changing needs of the child or young person. Transforming Care Partnerships were set up in 2015 for exactly this purpose, involving stakeholders across the health system and local authorities working together to ensure the best outcomes for those with learning disabilities and autism. As Mencap (a leading charity for people with learning disabilities) states on their website, “on average, people with a learning disability have worse health than people without a learning disability”. This is true for physical health and mental health and a lot of this is can be attributed to the way in which those with learning disabilities are treated by the health system rather than the condition itself being the only causal factor. Evidence shows that 28% of people with a learning disability die from avoidable causes, compared with 9% of the general population. This is an alarming statistic and one that can be reduced through a more integrated approach of care delivery.

A child with a learning disability is more likely to develop a mental health problem and find it more difficult to communicate their feelings to others. This can lead to long term consequences on their
health and wellbeing into adulthood. The pressure on the health system is therefore likely to rise if these issues are not addressed as soon as possible.

**Use of secondary care**

Looking at the last three years of activity data we know that most patients are being treated at East Kent hospitals and that the type of condition they are being treated for varies with age. For example:

- Children in their early years are usually admitted into hospital for respiratory problems and viral infections
- Primary school aged children are admitted for conditions relating to dental health and ear infections
- Secondary school aged young people exhibit problems associated with abominable pain and fractures
- Those aged 15-19 see a spike in the number of drug abuse related admissions

The average length of stay of most paediatric treatments including for the reasons mentioned above are under a single bed day which is in line with, if not better than, the national average. However, length of stay for asthma in children is ranked in the bottom 30% when comparing Kent and Medway to their NHS RightCare peers.

Future demand for paediatric services and secondary care use in Kent and Medway is expected to increase with predicted population growth and over 188,000 new homes to be built by 2031. With this growth comes additional pressures for hospitals within the area to deliver a high standard of service despite workforce constrains and financial pressures. Currently, only one trust in Kent and Medway is meeting more than 90% of clinical standards across all paediatric services and maternity, and only two out of the four trusts meet more than 90% of the standards for neonatal services (as shown in Exhibit 32).

**Exhibit 32 – Clinical standards audit across paediatric and maternity services in Kent and Medway**

<table>
<thead>
<tr>
<th></th>
<th>EKHUFT</th>
<th>MFT</th>
<th>MTW</th>
<th>DGT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternity</strong></td>
<td>![Maternity]</td>
<td>![Maternity]</td>
<td>![Maternity]</td>
<td>![Maternity]</td>
</tr>
<tr>
<td><strong>Neonatal</strong></td>
<td>![Neonatal]</td>
<td>![Neonatal]</td>
<td>![Neonatal]</td>
<td>![Neonatal]</td>
</tr>
<tr>
<td><strong>Paediatrics</strong></td>
<td>![Paediatrics]</td>
<td>![Paediatrics]</td>
<td>![Paediatrics]</td>
<td>![Paediatrics]</td>
</tr>
<tr>
<td><strong>Paediatric surgery</strong></td>
<td>![Paediatric surgery]</td>
<td>![Paediatric surgery]</td>
<td>![Paediatric surgery]</td>
<td>![Paediatric surgery]</td>
</tr>
</tbody>
</table>

- Service not provided
- Meets < 67% of standards
- Meets between 67% and 90% of standards
- Meets > 90% of standards

Source: Carnall Farrar analysis using Trust provided data 2016

The performance of different trusts was measured through a clinical standards audit commissioned by the Programme Board of the Kent and Medway STP. The various hospital sites across both areas were assessed on workforce, access and current pathways and compared against nationally...
recognised benchmarks. The key areas where no hospital fully meets standards are shown in Exhibit 33. We can see that there is a significant level of variation between different hospital sites particularly in relation to women being provided with 1:1 care from a midwife labour and a consultant paediatrician being present and readily available in the hospital for a minimum of 12 hours a day, seven days a week. In terms of patient outcomes, it means an inconsistent level of service across Kent and Medway where the level of care for children and young people can range from one hospital site having a dedicated paediatrician within A&E to another that does not.

Exhibit 33 – Clinical standards audit: deep dive into paediatric and maternity services

Source: Carnall Farrar analysis using Trust provided data, 2016
One result of this inconsistent level of service is variation in patient experiences and we can see below in Exhibit 34 that this is the case. The responses from received from the children and young people’s survey into patient experience show that all trusts in Kent and Medway are below the top quartile and top decile in the country and there are areas where improvements can be made.

Exhibit 34 – Results from children and young people’s survey into patient experience

| Did the ward where your child stayed have appropriate equipment or adaptations for your child’s physical or medical needs? (Average rating out of 10) |
|---|---|---|---|---|---|---|
| Dartford and Gravesham NHS Trust | Medway NHS Foundation Trust | East Kent Hospitals NHS Foundation Trust | Maidstone and Tunbridge Wells NHS Trust | National average | Top quartile | Top decile |
| 8.5 | 8.9 | 9.1 | 8.7 | 8.9 | 9.1 | 9.2 |

| When you left hospital, did you know what was going to happen next with your child’s care? (Average rating out of 10) |
|---|---|---|---|---|---|---|
| Dartford and Gravesham NHS Trust | Medway NHS Foundation Trust | East Kent Hospitals NHS Foundation Trust | Maidstone and Tunbridge Wells NHS Trust | National average | Top quartile | Top decile |
| 7.9 | 7.7 | 8.1 | 8.0 | 8.1 | 8.3 | 8.6 |

| Overall experience (Average rating out of 10) |
|---|---|---|---|---|---|
| Dartford and Gravesham NHS Trust | Medway NHS Foundation Trust | East Kent Hospitals NHS Foundation Trust | Maidstone and Tunbridge Wells NHS Trust | National average | Top quartile | Top decile |
| 8.2 | 8.3 | 8.4 | 8.4 | 8.5 | 8.7 | 8.8 |

Source: CQC Children and Young People’s Inpatient and Day Case Survey, 2016
The number of overall emergency attendances gives us a good indication of how well prevention and early intervention services are doing in Kent and Medway. Here, Medway are performing significantly worse than the national benchmark, whereas Kent are performing significantly better. Indeed, the trend in Medway can be seen since 2010 (as shown in Exhibit 35) and suggests that more can be done to ensure there is early detection of problems and intervention where necessary so that conditions are not allowed to deteriorate.

Exhibit 35 – Level of emergency admissions

A large part of these admissions shown above are caused by unintentional and deliberate injuries. In Medway, the rate of this is 115 admissions per 10,000 which is 17% higher than the regional benchmark and 11% higher than the national one. Unintentional and deliberate injuries can range from accidental slips and trips to more serious forms of self-harm and abuse. Indeed, these issues can signal wider problems within the younger person’s life such as mental ill health and child abuse.
5. Key challenges

5.1 There needs to be a greater focus on prevention, especially in more deprived areas

The majority of people in Kent and Medway are generally healthy and well – around 71% of local people use health and social care services only occasionally. Empowering people, families and communities to stay healthy, including having good mental health, means they need less health and social care in future. However, many of these people, especially those aged 40+, are at risk of developing long-term health conditions such as obesity, raised cholesterol and high blood pressure and the older people get, the more likely they are to have multiple long-term conditions and an increased sense of loneliness.

People who already have a long-term health condition can also be supported to reduce the risk of their condition becoming worse. For example, there are opportunities for better management and control of long-term health conditions in primary care. For example, within Kent and Medway in 2015/16, the number of people with detected high blood pressure who did not sufficiently lower their blood pressure, putting them at risk of stroke and other acute problems, ranged from 58% to 93% across GP practices.

Around 1,600 early deaths each year in Kent and Medway are considered potentially preventable if healthcare was more timely and effective. Indeed, medical conditions such as chronic obstructive pulmonary disease (COPD), a common cause of early death, are almost completely avoidable as most cases (85%) are caused by smoking. Exhibit 36 shows that Thanet, Swale and South Kent Coast have particularly high levels deaths that could have been avoided.

Exhibit 36 – Deaths that could have been avoided in Kent and Medway

<table>
<thead>
<tr>
<th>Observed premature deaths 2009 - 2013</th>
<th>Premature death as proportion of the CCG population, %, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male</strong></td>
<td><strong>Female</strong></td>
</tr>
<tr>
<td>2009</td>
<td>1,005</td>
</tr>
<tr>
<td>2010</td>
<td>1,004</td>
</tr>
<tr>
<td>2011</td>
<td>931</td>
</tr>
<tr>
<td>2012</td>
<td>903</td>
</tr>
<tr>
<td>2013</td>
<td>914</td>
</tr>
<tr>
<td>5 year average</td>
<td>951</td>
</tr>
</tbody>
</table>

Source: Public Health Outcomes Framework, 2014-15
People living in Kent and Medway are worse than the national average for a number indicators relating to health and wellbeing, such as levels of obesity, smoking rates and children living in poverty. These indicators are worse in more deprived areas such as Swale and Thanet, which helps to explain the higher number of preventable deaths. It is also worth noting that people living in poorer areas not only die sooner, but spend more of their lives with disability – an average of 17 years in total.

Exhibit 37 – Correlation between level of wealth and performance on indicators of poor future health outcomes

These health inequalities are caused by many things – housing, income, education, social isolation, disability – and these are strongly affected by economic and social status. Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community. Health and social care services cannot address all of these areas but can address some of them. To reduce health inequalities, the Marmot Review recommends that the highest priority be given to giving every child the best start in life and also to strengthen the role and impact of ill-health prevention. There is also evidence that increased investment in primary care can reduce health inequalities.

A focus on prevention and early intervention is therefore very important in improving health and wellbeing for local people, particularly those in more deprived areas. Despite this, only 2% of health and social care funding is spent on public health in Kent and Medway (that is, both care services and lifestyle intervention services to reduce the risk of avoidable disease and disability including programmes commissioned nationally) and budgets are expected to decline by 9% over the next 3 years (3% per year) through the reduction in the national Public Health Grant.

Source: Public Outcomes Framework – SEMI, Carnall Farrar analysis
Exhibit 38 – Planned reduction in public health budget

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Budget</th>
<th>Kent</th>
<th>Medway Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/17</td>
<td>£85.8m</td>
<td>£14.7m</td>
<td>£71.1m</td>
</tr>
<tr>
<td>2017/18</td>
<td>£83.6m</td>
<td>£14.2m</td>
<td>£69.4m</td>
</tr>
<tr>
<td>2018/19</td>
<td>£81.0m</td>
<td>£13.4m</td>
<td>£67.6m</td>
</tr>
<tr>
<td>2019/20</td>
<td>£78.4m</td>
<td>£12.6m</td>
<td>£65.8m</td>
</tr>
</tbody>
</table>

Note: 1. Indictive from 2019/20 onwards
Source: Kent County Council, Medway Unitary Authority (November 2018)

This requires a focus on health promotion and ill health prevention, particularly around those who are healthy and well but are at risk of developing long-term health conditions. Investment in preventing ill health will be crucial to achieve this.

5.2 There are challenges in primary care, which is extremely fragile in some areas

Primary care includes GPs, practice nurses, pharmacists, opticians and dentists. They are usually the first point of contact for people with a health problem and are crucial in health promotion, treating minor illness, signposting to other health and social care services and managing people with more complex needs. Fragility within primary care is characterised by low numbers of GPs and practice nurses per head of population (meaning that access to primary care services is difficult), high vacancy rates and high locum use (meaning GPs and practice nurses do not know the patients or the services available locally). Nationally, funding for primary care is 8% of health spend; this should rise to almost 11% by 2020. Some people in Kent and Medway are unhappy with existing GP services; on average 76% would recommend their GP surgery to a friend, compared to 78% nationally (this varies between 68% in Medway CCG and 84% in Canterbury & Coastal CCG). People find it difficult to contact their GP surgery and there are long waits to be seen when they get there. This might be partly explained by the low number of GPs and practice nurses in many parts of Kent and Medway. As shown in Exhibit 39, half of the CCGs in Kent and Medway have low numbers of GPs and practice nurses compared to the national average, with particularly low levels of GPs in Thanet and Swale and practice nurses in Medway and Swale. This means that there would be 245 more full-time GPs and 37 more full-time practice nurses in Kent and Medway if the area had the same numbers as the national average. It is also worth noting again that Thanet and Swale are the most deprived areas in Kent and Medway.
There are also very high levels of vacancies across primary care in Kent and Medway, with an estimated 136 GP vacancies across Kent and Medway (12% of the total number of GPs), and 53% have been vacant for more than a year\textsuperscript{102}. This creates a dependency on locum GPs - on average locum doctors constitute 8% of the GP workforce in Kent and Medway\textsuperscript{103}. The situation is likely to get worse as 30% of GPs in Kent and Medway are aged 55 and over and are therefore expected to retire in the next 10 years\textsuperscript{104}. This is compared to 22% nationally\textsuperscript{105}. Furthermore, there are challenges in recruiting practice nurses; every single one of the vacancies reported in a recent survey of practices been open for more than 6 months\textsuperscript{106}.

In the face of these workforce pressures, we can see in Exhibit 40 that across a number of key benchmarks GP practices in Kent and Medway are underperforming against the national average. If we look at CCG level data, there is variation of as much as 10% on key measurables such as accessibility, helpfulness of reception staff and waiting times. There is therefore an opportunity for greater collaboration and learning from best practice so that lower performing practices can meet national and regional standards.
Exhibit 40 – GP survey data across Kent and Medway

There is also significant variation in the number of GP practices open 6 and 7 days a week. Exhibit 41 shows that in Ashford for example, just under 20% of GP practices are open 7 days a week whereas in West Kent and Thanet, no practice is open 7 days a week. On a national level, around 16% of GP practices are open at least 6 days a week and we can see below that surgeries in Medway, Swale and Dartford are not meeting this national benchmark. In addition to this, we can see in Exhibit 42 that there is also variation in late opening hours for GP practices across Kent and Medway. In Swale for example, around 50% of all GP practices are open after 7pm whereas in Thanet this is significantly less at only 13%. Reduced opening times and days means that many people will be unable to see a doctor during working hours and would therefore need to attend A&E should their condition worsen (increasing pressure on hospitals) or miss work which can entail a negative economic impact.

Some of these shortcomings when it comes to reduced opening days and opening times can be alleviated with a robust GP out-of-hours service. Out-of-hours primary care services are delivered by Integrated Care 24 (IC24) in East Kent, West Kent and Dartford, Gravesham and Swanley. Medway on Call Care (MedOCC) provide out-of-hours primary care services in Medway and Swale. In the latest CQC rating for IC24 in Kent, they were rated as being ‘Good’ for all areas including ‘Safe’, ‘Effective’ and ‘Caring’\textsuperscript{107}. The inspection summary also emphasised how the provider has introduced a comprehensive training programme for its clinical and non-clinical staff to ensure there is effective handling of controlled drugs and that prescription forms could be traced through the service to the patient. Similarly, in MedOCC’s latest inspection report\textsuperscript{108} they were also rated as ‘Good’ in all areas,
particularly highlighting the clear management structure and positive feedback received from patients.

The importance of effective and robust primary care provision should not go unnoticed and is a key factor in ensuring that there are robust prevention strategies in place for the population. Indeed, prevention is an essential task of primary care and its shortcomings in delivery are mainly due a lack of time. Whilst in some areas such as breast cancer screening and cervical cancer screening, both Kent and Medway are in line with the national average, in other areas they are performing worse (as shown in Exhibit 43). The message we can take from here, is that by ensuring primary care services are well resourced and managed, we can increase productivity and ensure more time is spent in the GP surgery promoting prevention strategies.

Exhibit 43 – Prevention indicators across Kent and Medway

Community pharmacy is also facing significant challenges; pharmacists nationally will see their funding fall over the next two years\textsuperscript{110}. The 335 pharmacies in Kent and Medway\textsuperscript{111} play a central role in the delivery of primary care via the provision of medication and associated products, information and practical help on keeping healthy\textsuperscript{112}. They are also taking on more of the clinical roles that have traditionally been undertaken by doctors; for example, the management of asthma and diabetes as well as blood pressure testing\textsuperscript{113}. Pharmacists may respond to the reduction in funding by taking steps to reduce costs, such as by reducing opening hours and staffing, or by stopping the provision of services they do not have to provide (such as the home delivery of medicines)\textsuperscript{114}.

Fragility in primary care services is an issue because it can lead to:

- Later identification of disease if early indicators of disease such as obesity and smoking are not identified and addressed in primary care. In Kent and Medway, for example, there are low levels of early detection of heart disease and dementia and low levels of immunisation for people with COPD\textsuperscript{115}.
- More complications and worsening of disease if monitoring of people with long-term conditions is not comprehensive. In Kent and Medway, for example, there are high lengths of stay in hospital for children with asthma\textsuperscript{116} and low numbers of asthma and arthritis patients who have had preventative reviews\textsuperscript{117}.
- Increasing activity in hospitals if local people use A&E rather than their local GP surgery for urgent care. In Kent and Medway, attendances at A&E departments has risen by around 3.6\% per year over the last three years, compared to 2.6\% nationally; this would be an increase in A&E attendances of over 70,000 per year by 2020/21 if noting changes\textsuperscript{118}. This is shown in Exhibit 44. If attendance continues to rise in line with current trends, we can expect that there will be over 560,000 people visiting A&E in 2020/21 (15\% higher than current levels).
- Pressure on mental health services if poor mental health is not identified until it results in a crisis. For example, in parts of Kent and Medway attendances to A&E for psychiatric disorder in adults is significantly higher than the national average\textsuperscript{119}. 


This requires that a priority area for focus is recruitment and retention of primary care staff, including GPs, in order to enhance prevention services, accessibility and overall patient experience.

Source: NHS England, Quarterly A&E activity data, Carnall Farrar analysis
5.3 There are gaps in service and poor outcomes for those with long-term health conditions

There are over 528,000 people in Kent and Medway with a significant long-term health condition and many people have multiple long-term health conditions, resulting in complex needs\textsuperscript{120}. The number of people with multiple long-term health conditions tends to increase as the population ages, as shown in Exhibit 45; in Kent one third of people over the age of 70 have three or more long-term health conditions such as asthma, diabetes and hypertension\textsuperscript{121}.

Exhibit 45 – Number of long-term health conditions in Kent and Medway by age

Many people with long-term health conditions do not feel supported to manage their condition – this is the case for up to 45\% of people in Dartford\textsuperscript{122}. There are also high levels of admissions to hospital for some people with chronic conditions. Evidence from elsewhere suggests that 25-40\% of hospitalisations could be reduced if there was better support for self-care and early intervention in the event of deterioration alternative care was available outside hospital\textsuperscript{123}.

Many people with long-term health conditions are looked after by unpaid carers, who are often elderly and may have their own long-term health conditions. However, health and social care services rely on these carers to support people who are ill. Fewer than half of all carers in Kent and Medway are satisfied with their experience of care and support and only a third have as much social contact as they would like\textsuperscript{124}.

This requires that a priority area for focus is avoiding hospital admissions for people with long-term conditions and supporting their carers.
5.4 Many people are in hospital who could be cared for elsewhere

When people go to hospital in Kent and Medway, they tend to stay in hospital for a long time and have difficulty getting out of hospital and back home. Every day over 1,000 people are in local hospitals when they could be elsewhere, as shown in Exhibit 46 (this is similar to other hospitals in England). The vast majority of these patients are over the age of 70 and more than half are over the age of 85. A third of all people in acute hospitals who are medically fit have been medically fit for over a week, whilst 43% of people in community hospitals have been medically fit for over a week.

Exhibit 46 – Proportion of people who are medically fit to leave hospital

<table>
<thead>
<tr>
<th>Hospital</th>
<th>% of people ‘fit to leave’ their current setting of care</th>
<th>Total number of occupied beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Kent Hospitals University Foundation Trust (Community)</td>
<td>36.2%</td>
<td>55</td>
</tr>
<tr>
<td>Medway Foundation Trust</td>
<td>36.4%</td>
<td>461</td>
</tr>
<tr>
<td>East Kent Hospitals University Foundation Trust</td>
<td>35.8%</td>
<td>915</td>
</tr>
<tr>
<td>Maidstone &amp; Tunbridge Wells Trust</td>
<td>34.2%</td>
<td>690</td>
</tr>
<tr>
<td>Kent Community Health Foundation Trust</td>
<td>33.0%</td>
<td>191</td>
</tr>
<tr>
<td>Dartford &amp; Gravesham Trust</td>
<td>28.5%</td>
<td>411</td>
</tr>
<tr>
<td>Medway Community Healthcare Trust</td>
<td>25.6%</td>
<td>43</td>
</tr>
<tr>
<td>Kent &amp; Medway NHS &amp; Social Care Partnership Trust</td>
<td>15.3%</td>
<td>413</td>
</tr>
</tbody>
</table>

Source: Carnall Farrar Analysis, 2016

When people are ready to leave hospital, local services are often not ready to look after them, so they must stay in hospital longer. More time spent in hospital does not necessarily mean better outcomes – often the reverse – and many people could be cared for sooner, at home. Longer stays are not always driven by medical need and can be harmful to health – the longer the stay, the greater the risk of getting infections, muscle decline, becoming less able to walk or do everyday tasks, less able to return home and more likely to need residential or nursing care. The loss of physical function, confidence and independence increases short and long-term care needs, which is not good for the individual and places an additional burden on care services. It is also expensive – it costs, on average, £220 per day to care for someone in an acute hospital bed and this money could be better used elsewhere. People would also rather not die in hospital; only 43% of people who die in Kent and Medway can do so in their usual place of residence, even though, given a choice, most declare their home to be their preferred place of death.

The impact delayed transfers have on providing elective and emergency care is also significant. Lack of available beds means whole operating teams being underutilised and becoming frustrated, and patients waiting longer for surgery. At the front door, maintaining flow in Emergency Departments relies on appropriate beds for patients to be admitted to and for clinical teams to have capacity to provide timely care.
Some of the main causes of delay are awaiting care home placement (14%) and awaiting a care package in their own home (14%)\(^1\). These services are often unable to accept transfers or set up care packages at weekends, so people who are medically fit are stuck in hospital and needing such support. In Kent and Medway, there are issues with:

- **The availability of social care**: the majority of patients medically fit to leave hospital require basic essential care such as feeding and washing\(^1\).\(^3\)
- **The quality of residential care**: over 40% of local residential care homes are rated as inadequate or requires improvement by the Care Quality Commission\(^1\).\(^4\)
- **The availability of nursing home care**: there are also issues with the availability of nursing home care; over the last year there has been a significant reduction in nursing home beds in Kent and Medway and 25 (8%) have closed in the last two years\(^1\).\(^5\)
- **Care outside hospital for people with dementia**: an estimated one third of the people who are in a hospital bed and are medically fit to leave also have dementia\(^1\) – and care homes are often unable to accept people with dementia, especially at short notice.

It is not always the case that external services are unwilling or unready to receive patients, indeed inefficiencies in discharge management within the hospital itself can cause unnecessary waits and longer length of stays. The charts in Exhibit 47 show us that within three individual months across the year, the proportion of delayed transfers arising as a result of lags in acute care is significantly greater than those arising from social care being unready to receive patients. Whilst gains in this area have been made in some parts of the region, it is important to learn from these success stories and replicate them wherever possible. In Medway for example, the implementation of the ‘Home First’ initiative to provide support for patients by arranging an independence programme led to a 25% drop in the number of delayed transfers of care over a three-month period last year\(^1\).\(^7\)

**Exhibit 47 – Causes of delayed transfers within Kent and Medway**

<table>
<thead>
<tr>
<th>Causes of delayed transfers of care within</th>
<th>Causes of delayed transfer of care within</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent</td>
<td>Medway</td>
</tr>
<tr>
<td>Jan-17</td>
<td>Jan-17</td>
</tr>
<tr>
<td>70%</td>
<td>79%</td>
</tr>
<tr>
<td>28%</td>
<td>17%</td>
</tr>
<tr>
<td>May-17</td>
<td>May-17</td>
</tr>
<tr>
<td>65%</td>
<td>73%</td>
</tr>
<tr>
<td>32%</td>
<td>24%</td>
</tr>
<tr>
<td>Sep-17</td>
<td>Sep-17</td>
</tr>
<tr>
<td>61%</td>
<td>76%</td>
</tr>
<tr>
<td>36%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Source: NHS England Statistics on Delayed Transfers of Care

Delays in discharge contribute to a poor experience for local people – especially at weekends– and can have a lasting negative impact on independent living. It also represents poor value for money because hospital services are being used by people who are medically fit to leave the hospital.

**This requires that a priority area for focus is reducing the length of stay in hospitals especially for older people, working in partnership with social care.**
As the causes of delayed transfers can be social care related, and in Kent and Medway represent around 60-70% of the reason, it is also important to highlight the performance of social care within the system. We can see below in Exhibit 48 that overall satisfaction for social care services in Medway is below the national benchmark, whereas in Kent it is slightly higher.

Exhibit 48 – Satisfaction for social care services

A partial explanation for the underperformance observed in Medway can be a shortage of staffing. Exhibit 49 below shows that for particular staff groups, vacancies are higher than the national benchmark.

Exhibit 49 – Workforce vacancies in social care

These workforce shortages can present a challenge in how social care is delivered and its responsiveness as a result. Exhibit 50 below shows that over half of all service users in Medway who have been accessing support for more than 12 months have not received a review of their care (planned or unplanned). This is concerning as care reviews are important to ensure that the user of social care is receiving the appropriate level of support, making sure that their mental or physical wellbeing has not deteriorated and ensuring that their support package is promoting their
independence. Unlike in Medway, the number of service users in Kent receiving a planned or unplanned review is above the national and regional benchmarks.

Exhibit 50 – Percentage of users of service users receiving a care review

| Percentage of all service users that have received a review in the last 12 months |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|
| Kent                            | 84%             | South East      | 61%             | England         | 59%             | Medway           | 45%             |

Source: Adult Social Care Activity and Finance Report, NHS Digital (2016/17)

5.5 Some local hospitals find it difficult to deliver services for seriously ill people

Some local hospitals are finding it difficult to provide care for a small number of seriously ill people who use hospital services. Exhibit 51 shows the most recent Care Quality Commission (CQC) ratings for local providers. As we can see, all four acute trusts in Kent and Medway ‘Require Improvement’ with very few having areas being defined as ‘Good’. No trust scored ‘Outstanding’ in any part of their rating. Hospitals need senior doctors seven days a week to make sure that there is someone with sufficient skill and experience to spot problems and deal with them, and that care is effective when it is needed. Doctors, nurses and technical staff also need a minimum number of cases to maintain the high levels of expertise needed in these services. Specialist tests and equipment also need to be available 24 hours a day. Evidence shows that it is better for seriously ill people to travel further for this more specialist care.

Exhibit 51 – Overview of CQC inspection ratings for the four acute trusts

<table>
<thead>
<tr>
<th>CQC rating</th>
<th>Dartford and Gravesham Trust</th>
<th>East Kent Hospitals University Foundation Trust</th>
<th>Maidstone and Tunbridge Wells Trusts</th>
<th>Medway Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Caring</td>
<td></td>
<td></td>
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<tr>
<td>Responsive</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Well-led</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of latest report</td>
<td>July-14</td>
<td>Dec-16</td>
<td>Feb-15</td>
<td>Mar-17</td>
</tr>
</tbody>
</table>

Source: Care Quality Commission 2017

There are a number of challenges facing services for some seriously ill people in Kent and Medway. There are some services in Kent and Medway that are small, and senior staff and specialist tests and equipment are not always available 24 hours a day. This leads to issues with junior doctor training.
which needs to provide the quality of experience, levels of clinical supervision and services that satisfy training requirements. There are also issues with services outside hospital, particularly at weekends, making it difficult for people to go home when they are able. This leads to delays along the patient pathway; including waits to be seen by a senior doctor, for diagnostic tests, for a hospital bed, for treatment and to leave the hospital. Exhibit 52 shows the effect that all these factors have had on standards. We can see that:

- Only 3 out of the 13 top specialities meet 90% of national standards across two or more trusts across Kent and Medway.
- Gynaecology is the only speciality meeting greater than 90% of standards across every trust within Kent and Medway.
- No one hospital meets 90% of standards in all services.
- Stroke is by far the worst performing service, failing to meet at least 67% of standards across every trust in Kent and Medway.
- A significant majority of trusts fail to meet at least 67% of standards for older people services and acute medicine

The implications of this can include a lack of senior staff available to effectively diagnose patients, diagnostic services being available only part time due to staff shortages, and waiting times for admission being significantly longer due to a lack of available bed capacity – all these factors lead to a further deterioration of services. Indeed, we can see how in Kent & Canterbury Hospital, emergency services for heart attack, stroke and pneumonia have been significantly reduced as a direct consequence of Health Education England finding the supervision of junior doctors there being inadequate. At the time of writing this Case for Change, training places at Kent & Canterbury Hospital have been paused with existing junior doctors being moved to neighbouring sites. As a result, trying to continue delivering these emergency services without sufficient staffing would be clinically unsafe and patients now have to travel further for an emergency medical need.
Examples of the key challenges that trusts are facing and that are contributing to the underperformances shown above include:

- **In stroke**, all the hospitals in Kent and Medway provide an emergency stroke service. There is now strong evidence that people who have a stroke need to have rapid access to a range of specialist interventions within the first 24 hours, in order to improve their chances of survival and minimise disability. Local standards are that all eligible patients should be thrombolysed within 60 minutes; none of the hospitals in Kent and Medway meet this standard and, in 2015/16, the worst performing trust only met the standard for 16% of cases. National guidelines also state that specialist doctors, nurses and therapists should be available 24 hours a day, 7 days a week; none of the hospitals in Kent and Medway achieve this across all three staff groups. Performance of local hospitals against a range of guidelines and targets is shown in Exhibit 53.

- **In vascular**, there are several national guidelines about the number of cases that need to be seen at each hospital, access to specialist teams and specialist imaging. There are two hospitals in Kent and Medway who provide emergency vascular services and neither meet the majority of the guidelines. At Medway Hospital for example, the number of people served is below the 800,000 minimum standard. Evidence shows that centres that treat higher volumes of patients get better outcomes: fewer people die and fewer are left with a long-term disability.

- **In acute medicine**, workforce constraints prevent the delivery of 7 day services and 24/7 consultant cover across most hospitals in Kent and Medway. National evidence shows that delays to consultant reviews and a lack of senior medical involvement in patient care are consistently linked to poor patient outcomes. In some hospitals in Kent and Medway, senior doctors are not present at the weekend or are trying to cover more than one clinical
area at a time\textsuperscript{147}. Support services for discharge are also not always available at the weekend including pharmacy, social care and mental health liaison. This means people stay in hospital longer than they might if these services were available\textsuperscript{148}.

Exhibit 53 – Performance of hospitals in Kent and Medway against stroke standards and targets

<table>
<thead>
<tr>
<th>Aims</th>
<th>National recommendation/Target</th>
<th>DVH</th>
<th>MFT</th>
<th>MH</th>
<th>TWH</th>
<th>WHH</th>
<th>K&amp;C</th>
<th>OEQM</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid and accurate diagnosis</td>
<td>Imaging within one hour of admission</td>
<td>50%</td>
<td>50%</td>
<td>55%</td>
<td>56%</td>
<td>61%</td>
<td>59%</td>
<td>69%</td>
<td>48%</td>
</tr>
<tr>
<td>Direct admission</td>
<td>Patients admitted directly onto a specialist stroke unit within four hours</td>
<td>41%</td>
<td>43%</td>
<td>56%</td>
<td>41%</td>
<td>53%</td>
<td>51%</td>
<td>60%</td>
<td>58%</td>
</tr>
<tr>
<td>Immediate access to treatment</td>
<td>Thrombolysis within 60 mins</td>
<td>84%</td>
<td>79%</td>
<td>87%</td>
<td>67%</td>
<td>84%</td>
<td>88%</td>
<td>85%</td>
<td>84%</td>
</tr>
<tr>
<td>Specialist centres with sufficient numbers of patients and expert staff</td>
<td>Assess patients by specialist stroke consultant and within 24 hours.</td>
<td>22%</td>
<td>67%</td>
<td>35%</td>
<td>39%</td>
<td>24%</td>
<td>26%</td>
<td>37%</td>
<td>39%</td>
</tr>
<tr>
<td>Rapid assessment</td>
<td>Assess patients by stroke trained nurse and therapist within 24 hours.</td>
<td>91%</td>
<td>87%</td>
<td>91%</td>
<td>88%</td>
<td>87%</td>
<td>91%</td>
<td>89%</td>
<td>88%</td>
</tr>
</tbody>
</table>

Source: K&M Case for Change stroke, South East Coast Clinical and Quality standards for stroke, SSNAP audit (April 2015-Mar 2016)

The ambulance service is also extremely stretched with increasing numbers of calls, especially time critical calls, and a deterioration in response times over the last three years; between 2012 and 2016 the number of Red 1 (serious and time critical) emergency calls to South East Coast Ambulance Service rose by 265\% - 17 times faster than the national average of 16\% whilst the proportion of total calls responded to within the national 8 minute target fell by 10\% (from 75\% to 65\%)\textsuperscript{149}. The implications for patients include unnecessary waiting times to be transported and a deterioration of their physical condition if not treated in the appropriate time. Exhibit 54 shows the proportion of patients who are diagnosed with a confirmed STEMI (a very serious type of heart attack) and receive an appropriate care bundle in time such as an administration of aspirin or analgesia. This is a key indicator that ambulance clinicians use to measure quality and we can see for the South East Coast Ambulance Service, they have diverged from the national average in recent years, with a 14\% difference in 2016/17.
Exhibit 54 – South East Coast Ambulance Service: patients receiving a care bundle in time

The performance of the ambulance service when it comes to response times varies. As shown in Exhibit 54a below.

Exhibit 54a – South East Coast Ambulance Service: performance across category A and category C calls (17/18)

Source: Ambulance Quality indicators, NHS England

Source: SECAmb Trust data return (17/18)
We can see that for:

- R1 and R2 calls, which are defined as being ‘immediately life threatening’ and can include breathing difficulties or cardiac arrest. These require a response time within 8 minutes. As we can see in Exhibit S4a, this standard is only being met around 50-60% of the time on average.

- For Cat 1 calls, which require a 20 minute response time and include problems such as a sickle cell crisis, only around 46% of standards were met across a two month period on average.

- For Cat 2 calls, which require a 30 minute response time and include problems such as a fall with deformed limb, around 69% of calls are met in this time on average.

- For Cat 3 calls, which require a 60 minute response time and include problems such a miscarriage or vaginal bleeding, around 81% of calls are met in this time on average.

- For Cat 4 calls, which require a 1-4 hour response time and include problems such as a fall with no injury, around 77% of calls are met in this time on average.

- Overall, for all types of calls, around 60% of standards are being achieved. During the autumn months this falls by around 20%.

South East Coast Ambulance service have also had a problem retaining paramedic practitioners. This staff group receive tailored training and are able to treat patients in the community, refer them to a GP or decide if they should go to hospital. They can also administer stronger pain relief compared with standard paramedics and are able to assess if a wound need stitches. South East Coast Ambulance have had over 320 paramedic practitioners through their dedicated training programme over the past 10 years and there are currently 47 whole-time equivalents in post (as of February 2018).

The Nuffield Trust reports that in order to address all these concerns several factors need to be considered. These include ensuring we can effectively recruit and retain staff by promoting staff morale and through more effective management. Better coordination with trusts will also contribute to a reduction in the number of ambulance diversions that can negatively impact response times overall.\(^{150}\)

The challenges faced by providers and ambulance trusts altogether result in poorer access for patients and a poorer quality of service; several hospitals in Kent and Medway have some of the worst patient satisfaction scores in the country for A&E. This is shown in Exhibit 55. Quality of services is the main issue of concern raised by patients accessing services in some parts of Kent and Medway.\(^{151}\)
Exhibit 55 - Patient satisfaction scores for hospitals in Kent and Medway

Friends & Family Test Scores
% positive recommendations to friends and family

The answer is not simply to recruit more doctors, however. Although there is a shortage of doctors in some specialties, even if the workforce was available, local doctors would not see enough patients to maintain their skills. All local hospitals are having problems recruiting and retaining staff; as shown in Exhibit 56, there are average vacancy rates of around 8% and turnover of medical staff is 16%.
This requires a focus on specialised services which need to be configured so there is sufficient senior workforce to continue to provide high quality services. This needs to be balanced against the need to provide local access to services, where possible.

5.6 Planned care is not delivered as efficiently and effectively as it could be

Planned care (or elective care) relates to services and treatments that are not carried out in an emergency and often result from GP referrals. Within many local health systems, there exists competing pressures in terms of how best to allocate the resources needed to effectively deliver planned care whilst also trying to meet the daily demands of the A&E or emergency department. Reducing the number of elective admissions may benefit A&E performance by increasing the capacity to admit more emergency patients, but it will also result in longer waiting times and length of stays in elective care. On the other hand, increasing capacity in planned care will mean reduced capacity to meet the four-hour A&E standard and may also result in more outsourced work to meet these demand pressures. There is a difficult choice to be made – one which could be made easier if there was less variation in how GPs make referrals and in how elective procedures are carried out.

When people have a planned procedure or operation, it is usually done through a referral from a GP and then an outpatient appointment with a specialist; this may result in a planned procedure or operation, which can be done either as a day case or as a case with an overnight stay. It should be possible to standardise planned care according to best practice across Kent and Medway and therefore deliver it as efficiently as possible. This might mean referring someone to a different service for some issues (or not referring at all) or standardising the way in which operations are done.
Reducing variation and promoting standardisation is good for patient care and there is evidence which shows this. The South West London Orthopaedic Centre (SWLEOC) is nationally recognised as a centre of excellence in the delivery of patient-focused elective orthopaedic care, delivering a £3m surplus annually. SWLEOC was set up in 2004 as a joint venture between four local trusts in south west London to address the growing elective waiting list problem where patients could wait up to 4 years to be operated on. Through specially designed pathways, standardisation of processes and a focus on continuous improvement, SWLEOC is now the largest hip and knee replacement centre in the UK, performing 5,200 procedures a year and consistently achieving the 18 week target and low average lengths of stay\textsuperscript{156}. The scale of the joint venture has also enabled price negotiation, performance improvements and innovation (particularly when it comes to delivering a near paperless service). Lessons can be learned from this case study, particularly of the benefits that can be achieved through standardisation and creating a more uniformed service when treating elective patients.

Therefore, for planned care where there currently exists variation, there should be similar levels of referrals from GPs to specialists (once differences in the local people, such as age and deprivation, are taken into account). Once the patient gets to see the specialist, there should also be similar processes and patient experience. There are many reasons why this might not happen and why variation currently exists, including differences in: the health needs of local people, the skills and experiences of GPs, the ability of GPs to get a specialist opinion and access to diagnostics in primary care. Additionally, a key cause may be the rise in numbers of people accessing hospitals for urgent health problems, as this reduces the number of available beds, theatres and staff for planned care as outlined previously.

As shown in Exhibit 57, the level of referrals from GPs to hospital specialists in Kent and Medway are higher than other places with a similar population\textsuperscript{157}. This may reflect different levels of patient need, or it may be due to differences in clinical practice between doctors and nurses at any point where care is given. However, if the level of referrals were the same as top performing CCGs in similar areas, outpatient activity would reduce by 9\%\textsuperscript{158}. If planned activity in hospitals were the same as top performing areas CCGs in similar areas, it would reduce by 14\%\textsuperscript{159}.
There are also differences between hospitals in the delivery of planned care. For example, a recent Monitor report concluded that patients with planned major hip procedures could be reduced\textsuperscript{160}. The Right Care work shows the biggest potential opportunity for Kent and Medway for elective care is musculo-skeletal with a potential £7.8m savings along the pathway\textsuperscript{161}. 

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\textsuperscript{1} Peer benchmark calculated as top quartile of activity rates of 10 closest CCG peers identified for each K&M CCG by NHS Right Care

Source: MAR data; NHS Right Care peers; Carnall Farrar analysis
As mentioned earlier, one potential cause of differences in the delivery of planned care is levels of emergency care. Exhibit 58 shows that emergency activity is increasing and so are occupancy rates (the proportion of beds that are full in the hospital) which may explain some of the issues in delivering planned care.

Exhibit 58 – Levels of emergency activity and bed occupancy in Kent and Medway acute hospitals

![Graph showing average overnight bed occupancy and emergency admissions across all acute Trusts in Kent and Medway]

Note: the overnight bed occupancy rate is defined as the average daily number of beds occupied overnight that are under the care of consultants as a proportion of all available beds.
Source: NHS England, quarterly data from FY2013 to FY2015; Carnall Farrar analysis

This requires a focus on reducing differences in referrals into planned care, and the differences in the delivery of planned care within hospitals, including the relationship with emergency services.

5.7 There are particular challenges in the provision of cancer care

There are many opportunities to save lives and deliver cancer services more efficiently in Kent and Medway. More than 1 person in 3 will develop cancer at some time in their lives, and 1 in 4 will die of the condition. Cancer can develop at any age, but it is most common in older people – more than 3 out of 5 new cancers are diagnosed in people aged 65 or over, and more than a third are diagnosed in those aged 75 or over. There are over 48,000 people with cancer in Kent and Medway, including 175 children, and the cost for each person with cancer is over 6 times that for a generally healthy person. Mortality from cancer in Kent and Medway is similar to other parts of England. However, compared to other countries such as Sweden, the UK has much lower survival rates, suggesting that improvements could be made. 1-year survival rates from cancer are significantly lower than the national average in Medway and in the two most deprived CCGs: Swale and Thanet.

Late diagnosis of cancers is a particular issue that contributes to lower one-year survival rates. Exhibit 59 indicates that the percentage of cancers detected at an early stage is generally low in Kent and Medway, especially in Ashford and Canterbury & Coastal CCGs. Medway and Swale CCGs also have high numbers of people getting their first diagnosis of cancer when they present as an emergency patient in hospital; patients with cancers that present as an emergency have

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significantly worse outcomes\(^\text{170}\). There is particularly low awareness of the symptoms of cancer amongst black and minority ethnic groups\(^\text{171}\).

**Exhibit 59 – Percentage of cancers diagnosed at an early stage or as an emergency**

<table>
<thead>
<tr>
<th>Location</th>
<th>Proportion of cancers* diagnosed at early stage (stage 1 or 2)</th>
<th>Proportion of all malignant cancers** which present as an emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Kent</td>
<td>50</td>
<td>24</td>
</tr>
<tr>
<td>D,G,&amp;S</td>
<td>48</td>
<td>22</td>
</tr>
<tr>
<td>Medway</td>
<td>46</td>
<td>20</td>
</tr>
<tr>
<td>K&amp;M</td>
<td>43</td>
<td>19</td>
</tr>
<tr>
<td>Swale</td>
<td>43</td>
<td>19</td>
</tr>
<tr>
<td>South Kent Coast</td>
<td>37</td>
<td>19</td>
</tr>
<tr>
<td>Thanet</td>
<td>37</td>
<td>19</td>
</tr>
<tr>
<td>C&amp;C</td>
<td>34</td>
<td>19</td>
</tr>
<tr>
<td>Ashford</td>
<td>33</td>
<td>18</td>
</tr>
</tbody>
</table>

Notes: *Invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas, and melanomas of skin  
**Excluding non-melanoma skin cancer.

Source: Public Health England – Cancer Outcomes: Stage at Diagnosis and Emergency Presentations (average of quarterly data FY2013)

Low levels of take-up for cancer screening is one reason for late diagnosis of cancer. Although screening take-up in Kent and Medway is similar to the national average, less than 60% of the targeted population has bowel cancer screening and only 76-77% have breast cancer screening\(^\text{172}\).

Once cancer is suspected, waiting times to see a specialist and then for treatment are long across Kent and Medway\(^\text{173}\), as shown in Exhibit 60.
Exhibit 60 – Cancer wait times compared to national average (providers)

<table>
<thead>
<tr>
<th>Metric, unit of measure</th>
<th>EKHFU</th>
<th>DGT</th>
<th>MIWT</th>
<th>MFT</th>
<th>National median</th>
<th>National upper quartile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two week wait from GP urgent referral to first consultant appointment¹, %</td>
<td>90.8</td>
<td>92.0</td>
<td>91.1</td>
<td>86.7</td>
<td>95.0</td>
<td>96.5</td>
</tr>
<tr>
<td>Two week wait breast symptomatic (where cancer not initially suspected) from GP urgent referral to first consultant appointment¹, %</td>
<td>86.7</td>
<td>94.7</td>
<td>90.8</td>
<td>93.3</td>
<td>96.4</td>
<td>97.8</td>
</tr>
<tr>
<td>31 day wait from a decision to treat to a first treatment for cancer², %</td>
<td>95.6</td>
<td>100.0</td>
<td>96.6</td>
<td>92.6</td>
<td>98.6</td>
<td>99.4</td>
</tr>
<tr>
<td>31-day wait from a decision to treat to a subsequent treatment for cancer (surgery)¹, %</td>
<td>89.0</td>
<td>100.0</td>
<td>77.2</td>
<td>95.2</td>
<td>97.8</td>
<td>100.0</td>
</tr>
<tr>
<td>62-day wait from GP urgent referral to a First treatment¹, %</td>
<td>86.0</td>
<td>86.7</td>
<td>86.9</td>
<td>71.5</td>
<td>85.2</td>
<td>87.9</td>
</tr>
<tr>
<td>Overall cancer patient experience², scored out of 10</td>
<td>8.4</td>
<td>8.6</td>
<td>8.8</td>
<td>8.6</td>
<td>8.7</td>
<td>8.8</td>
</tr>
</tbody>
</table>


Nationally, the number of referrals to cancer specialists have almost doubled over the last five years¹⁷⁴. This may be partly due to current guidance, but may also reflect both increasing demand from local people, and issues with access to diagnostic tests and specialist advice in primary care. There are also delays in seeing a specialist, often caused by long waiting lists for diagnostics¹⁷⁵. Patient satisfaction with services is also low for most of the acute providers¹⁷⁶.

By 2030, it is estimated there will be as many as 90,900 people in Kent and Medway living with and beyond cancer, a potential increase of approximately 67% from 2014 (or 36,400 cases). The Kent and Medway Cancer Alliance is a joint initiative across the STP which has been set up to address this issue. Involving clinicians, the local authority as well as patients all coming together to develop strategies that deliver improved outcomes for those diagnosed with cancer as well as increasing the uptake of screening. Data shows that the incidence of cancer in Kent and Medway is disproportionately higher in areas of greater deprivation such as in Swale and Thanet. This is an area where the Cancer Alliance are particularly keen to address – reducing the cancer-related health inequalities across the region.

This requires a focus on improving efficiency, quality and access on the cancer pathway across primary and acute providers.

5.8 People with mental ill health have poor outcomes and may not always be able to access services

It is important that mental health has equal priority with physical health, that discrimination associated with mental illness ends and that everyone who needs mental health care should get the right support, at the right time. More must also be done to prevent mental illness and promote mental wellbeing¹⁷⁷.
There is a lot of evidence that links poor physical health with mental illness. For example, having depression doubles the risk of developing coronary heart disease – and people with depression have significantly worse survival rates from cancer and heart disease. People with a serious mental illness are at risk of dying on average 15 to 20 years earlier than the general population.

Spend per head on physical health care for those with mental illness combined with long-term physical health conditions is almost 50% higher than for those with only long-term physical health conditions. People with a long-term condition and a mental illness spend longer in hospital, have more investigations and make slower recovery. They are also more likely to die – for example, people with diabetes and comorbid depression are 36-38% more likely to die early as those without depression. Children with diabetes and depression are much more likely to get long-term damage to their eyes. People with a mental illness are also less likely to be able to manage their own illness and more likely to do things that will make their long-term condition worse, such as smoking or drinking.

Nationally, years of low prioritisation have led to CCGs underinvesting in mental health services relative to physical health services. There is widespread dissatisfaction with services, particularly for crisis care and changes in who the person sees. There are also problems with recruiting and retaining staff; for example, the vacancy rates for medical staff in mental health is 31%. At any one time, around 14% of patients in a mental health hospital bed are fit to leave. Over half of all these patients require further social care or overnight support to be discharged to their normal place of residence. A recent audit of patients in mental health beds found that the primary reason for delayed discharge is due to patients “awaiting completion of assessment” or “awaiting a health package of care”.

This requires a focus on the provision of mental health services, particularly the physical health of those with a mental illness, early diagnosis and access to integrated services.

5.9 There is a substantial financial challenge and services could be run more productively

There is a substantial financial challenge facing health and social care organisations in Kent and Medway. If nothing changes, health commissioners and providers will be £486m in deficit by 2020/21. Exhibit 61 summarises the ‘do nothing’ financial gap for Kent and Medway.
The consequence of doing nothing is that local health and social care services would not be maintained. A new way of providing services is needed, that can be delivered within the funding available. This cannot be done by one organisation, but needs to be done across health and social care, with everyone working together.

Although local providers have comparable levels of efficiency to hospitals of a similar type in many areas of spend, and some are amongst the most efficient, all providers in Kent and Medway could do more to reduce costs and run services more efficiently, including through increased collaborative working and reduced duplication. It is estimated that approximately £190m of savings could be made if services were run as efficiently as top performing hospitals of a similar type\(^{189}\). Key areas for focus are nursing staff, medical staff, agency staff and clinical supplies and services.

The ‘Getting it Right First Time’ (GIRFT) programme is a national initiative seeking to bring about higher quality care in hospitals, at lower cost, by reducing unwanted variations in services and practices\(^ {190} \). GIRFT is a clinically led programme, which brings together the clinical, performance and financial data for each specialist unit, making it easier to see the relationship between outcomes and cost and the opportunities standardisation and learning from best practice can achieve. It is important for Kent and Medway to be involved in this work in order to replicate the productivity and quality gains that are being observed in many other parts of the country and achieve efficiency savings.

This requires a focus on improving productivity across providers in Kent and Medway in order to tackle the financial challenge.
6. Enablers

6.1 Workforce
Throughout this case for change, the issue of workforce and the difficulty recruiting and retaining staff has been a common theme. The quality of care and patient/client experience is dependent on having a well-trained, motivated and experienced workforce and staff in Kent and Medway work very hard to deliver high quality services. However, there are several workforce challenges in Kent and Medway including:

- **Recruiting and retaining staff:** there are very high levels of vacancies across primary care, with an estimated 136 GP vacancies across Kent and Medway (12% of the total number of GPs), of which 53% have been vacant for more than a year\(^{191}\). This creates a dependency on locum GPs - on average locum doctors constitute 8% of the GP workforce in Kent and Medway\(^{192}\). There are also challenges in recruiting practice nurses; every single one of the vacancies reported in a recent survey of practices been open for more than 6 months\(^{193}\). There are also problems with recruiting and retaining staff in mental health services; for example, the vacancy rates for medical staff in mental health is 31%\(^{194}\). In social care, the cost of living in some areas in West Kent makes it very difficult to recruit staff (for example, the cost of buying a house is almost double in West Kent compared to East Kent\(^{195}\).

- **Availability and skills of staff:** there are low numbers of GPs and practice nurses compared to national average and many hospital services in Kent and Medway that are small where senior staff are not always available 24 hours a day. The answer is not simply to recruit more doctors. Although there is a shortage of doctors in some specialties\(^{196}\), even if the workforce was available hospital doctors would not see enough patients to maintain their skills\(^{197}\).

- **Carers:** many people with long-term health conditions are looked after by unpaid carers, who are often elderly and may have their own long-term health conditions. However, health and social care services rely on these carers to support people who are ill. Fewer than half of all carers in Kent and Medway are satisfied with their experience of care and support and only a third have as much social contact as they would like\(^{198}\).

To transform services, it will be crucially important to make sure that a skilled, experienced and committed workforce is in place. A medical school might help overcome issues with the attraction and retention of a clinical workforce in Kent and Medway, building on the training already delivered for the non-medical workforce. Research shows that 70% of UK doctors hold their first career post in the same region as either their home, medical school or their place of training\(^{199}\). Workforce is a key issue that needs to be considered and addressed as new service models are developed and implemented.

6.2 Estates are generally good but not always fully utilised
Generally, the hospital estate within Kent and Medway is relatively new and fit-for-purpose, especially when compared with England averages\(^{200}\). There are new PFI (public finance initiative) hospitals in Pembury (Tunbridge Wells Hospital), Dartford (Darent Valley Hospital) and Gravesend (The Gravesham Community Hospital). The William Harvey Hospital and the Kent & Canterbury Hospital have the oldest and least fit-for-purpose estate (although still in line with the national average)\(^{201}\). There is much more mental health estate that is old and not fit-for purpose; for example, the Thanet Mental Health Unit, of which 87% is not fit-for purpose\(^{202}\). GP practices are in reasonably good condition; for example, only 14 of 101 practices (14%) have a red rating for quality of accommodation\(^{203}\).
Furthermore, there is space in community hospitals that is not being used. Exhibit 62 shows the occupancy rates across different community hospitals in Kent and Medway.

**Exhibit 62 – Community hospital bed occupancy rates**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Ward</th>
<th>Ward type</th>
<th>Open Beds</th>
<th>Occupancy Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faversham Cottage Hospital</td>
<td>Cottage Ward</td>
<td>Rehab/Assessment</td>
<td>25</td>
<td>91%</td>
</tr>
<tr>
<td>Whitstable &amp; Tankerton Community Hospital</td>
<td>Friends Ward</td>
<td>Medical</td>
<td>18</td>
<td>93%</td>
</tr>
<tr>
<td>Queen Victoria Memorial Hospital</td>
<td>Heron</td>
<td>Rehab</td>
<td>23</td>
<td>91%</td>
</tr>
<tr>
<td>Deal Community Hospital</td>
<td>Elizabeth Ward</td>
<td>Rehab</td>
<td>22</td>
<td>90%</td>
</tr>
<tr>
<td>Hawkhurst Community Hospital</td>
<td></td>
<td>Community Hospital</td>
<td>22</td>
<td>92%</td>
</tr>
<tr>
<td>Edenbridge Community Hospital</td>
<td>Heron</td>
<td>Community Hospital</td>
<td>14</td>
<td>89%</td>
</tr>
<tr>
<td>Tonbridge Community Hospital</td>
<td>Goldsmit And Primrose &amp; Somerhill</td>
<td>Community Hospital</td>
<td>22</td>
<td>93%</td>
</tr>
<tr>
<td>Sevenoaks Community Hospital</td>
<td>Stanhope And Holmesdale</td>
<td>Community Hospital</td>
<td>19</td>
<td>93%</td>
</tr>
<tr>
<td>Amherst Court</td>
<td>Britannia Suite</td>
<td>Rehab</td>
<td>12</td>
<td>100%</td>
</tr>
<tr>
<td>Amherst Court</td>
<td>Endeavour</td>
<td>Stroke Rehab</td>
<td>15</td>
<td>93%</td>
</tr>
<tr>
<td>Frindsbury Hall</td>
<td>Rehab Unit</td>
<td>Rehabilitation</td>
<td>10</td>
<td>90%</td>
</tr>
<tr>
<td>Wisdom Hospice</td>
<td>Inpatient Unit</td>
<td>Palliative Care</td>
<td>15</td>
<td>53%</td>
</tr>
</tbody>
</table>

Source: Trust data (November 2016 for MCH and February 2018 for KCHFT), Carnall Farrar analysis

Notes:
- Data for the community hospitals in Sittingbourne and Sheppey were not provided and are therefore not shown above
- Wisdom Hospice is not defined as being a community hospital but it is included above as it is a part of Medway Community Healthcare

6.3 Information technology needs to better support integrated care

Information sharing between people and between organisations is essential to deliver safe, effective and efficient care. Information sharing supports people to stay healthy, multi-professional teams to deliver integrated care and organisations to identify opportunities to reduce variation, waste and clinical harm. Patients and the public expect to be told who is using their information, why it needs to be shared, who has access to it and what safeguards have been put in place to keep it secure. They also increasingly expect information to be shared with them, in a format they understand, and to help them to contribute their own data and let their care preferences be known. Furthermore, understanding of the disease and people at risk of ill health is important for commissioning across health and social care.

The NHS Digital Maturity Assessment provides a framework against which healthcare providers and CCGs can assess their progress towards digital adoption. Digital maturity in primary care is measured against core, enhanced and transformational IT compliance. Most CCGs in Kent and Medway agree that they are performing well against the “core IT compliance” indicators, however, no CCG in Kent and Medway currently meets the requirement for at least 80% of elective referrals made using the NHS e-referral system and there are issues with data quality across Kent and Medway. CCGs in Kent and Medway have lower compliance with the requirements for IT support for extended hours and for 7 day services. There is mixed performance in terms of “transformation in primary care”, which forms a later stage in digital maturity and covers indicators such as Wi-Fi for all clinical staff, auditable electronic records in local community and consistent local data sharing. This is shown in Exhibit 63.
Similarly, Exhibit 64 demonstrates that the level of digital maturity of provider organisations varies across Kent and Medway and local capabilities are generally low. \(^{205}\)
Exhibit 64 – Digital maturity assessment by provider of acute, mental health, social and community care services

<table>
<thead>
<tr>
<th>Section</th>
<th>Description of assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readiness</td>
<td>Organisation’s ability to plan, deliver and optimise the digital systems it needs to operate paper-free at the point of care</td>
</tr>
<tr>
<td>Capabilities</td>
<td>Digital capabilities available to the organisation and extent to which those capabilities are available and being optimised across the organisation as a whole</td>
</tr>
<tr>
<td>Enabling Infrastructure</td>
<td>Extent to which the underpinning infrastructure is in place to support delivery of these capabilities</td>
</tr>
</tbody>
</table>

Notes: Each answer is assigned a score from 0 to 100, where 0 represents ‘disagree completely’ and 100 ‘agree completely’

Source: NHS England, Digital Maturity Assessment 2015-16
7. Next steps

This case for change has shown the significant scale of the challenges in Kent and Medway and the urgency with which they need to be addressed. We need to address these challenges to make sure that local people are supported to be independent, that when they need high-quality care they can find it as close to home as possible, and that they can enjoy the health and wellbeing they aspire to. This must be supported by a Kent and Medway health and care system which works effectively and sustainably.

Across Kent and Medway there are many examples of excellent work taking place to improve the way people are cared for. For example, in Swale, integrated care teams made up of community nurses and social care practitioners have been introduced and attached to general practice clusters, allowing more joined up care. In Herne Bay, 7-day access to a range of urgent and outreach services, including diagnostics, have resulted in better patient experience and reduced admissions to hospital and A&E attendances. In the South Kent Coast area, rheumatology care is being delivered closer to home, supporting self-care, making space in hospitals and developing primary care skills and knowledge.

While these improvements are promising, they are only happening in some parts of Kent and Medway. The changes we need to make are greater than those already made, and so we must work together on a scale greater than we have before.

In this spirit, health and social care commissioners and providers across Kent and Medway – from the NHS, local authorities, public health and other organisations – have come together to create a 5-year Sustainability and Transformation Partnership (STP). This way we can learn from local successes and make the most of them and we can make sure that the quality of care is consistently high across Kent and Medway.

The aim of the STP is to meet the challenges outlined in this Case for Change, to deliver clinical and financial sustainability for health and social care in Kent and Medway and, most importantly, to improve quality of care and outcomes for local people. This means trying to meet the ‘needs’ of the local population as opposed to meeting their ‘wants’. There exists a clear distinction between the two, with the former having the potential to deliver improved outcomes for the local population.

This is an exciting opportunity to change how we provide care. We are exploring and pursuing opportunities around four key themes:

1. **Care transformation**: preventing ill health, intervening earlier and bringing excellent care closer to home.
2. **Productivity**: maximising efficiencies in shared services, procurement and prescribing.
3. **Enablers**: investing in buildings, digital infrastructure and the workforce needed to deliver high-performing health and social care services.
4. **System leadership**: developing the commissioner and provider structures which will deliver the greatest impact.

We will focus more on preventing ill-health and promoting good health and our local care will improve the health of people in Kent and Medway. This means supporting people to lead healthy lives, as well as reducing demand and costly clinical interventions. We also need a greater focus on people whose health outcomes are the worst.
A key element of the STP is partnership working – we will work with local people to transform local care through the integration of primary, community, mental health and social care and re-orientate some parts of traditional hospital care into the community. This allows patients to get joined-up care that considers the individual holistically – something patients have clearly and consistently told us they want.

We believe the way to achieve this is to enhance primary care by wrapping community services around a grouping of GP practices, to support the communities they serve, so that we can:

- Meet rising demand for health and social care, including providing better care for frail elderly people, people at the end of life, and people with complex needs;
- Deliver prevention interventions across Kent and Medway, improve the health of local people, and reduce the reliance on institutional care;
- Reduce the number of people in hospitals and instead support them in the community.

Clinical evidence tells us that many patients, particularly the elderly frail, who are currently supported in an acute hospital are better cared for outside hospital. Changing the location of care for these individuals will be truly transformational. We know it is possible to deliver this change and already have local examples to build upon where this new approach is being delivered (such as the Encompass Vanguard comprising 16 practices in east Kent who are operating as a multi-specialty community provider, providing a wide range of primary care and community services to 170,000 people).

In response to this, hospital care will need to change to improve patient experience and outcomes; make best use of the available workforce; and make best use of our buildings. We want to continue to create centres of hospital clinical expertise that see a greater separation between planned and emergency care. This would end the current issue of surgery being delayed because of pressure on beds for emergency patients. Through this we will deliver targets; increase the availability of senior staff, improve staff retention and morale; and release significant savings, even after investment in care outside hospital.

With these plans, we are confident that we can overcome the challenges which our health and care system faces and provide the high quality services and outcomes for local people.

Critical to the way we work together has been the establishment of several joint oversight boards, including the Clinical Board. This group includes GPs, hospital consultants, nurses, public health professionals, social care leads, pharmacists and other clinical experts. This group commissioned this Case for Change report and will oversee the plans to resolve the challenges it highlights. This will make sure the changes we propose are led by clinical expertise and experience.

Over the coming months, health and care professionals across Kent and Medway will continue work around the four transformation themes. Through this process, we will engage patients and service users, carers and local residents to ensure their views are heard and considered. Some improvements will start to be made immediately and some will need careful planning and preparation to be phased in over the coming months and years. Where there are significant changes, we will consult the public on our proposals and the options to make Kent and Medway services the best they can be.

This is an ambitious plan of work and we are committed to progressing it for the benefit of local people.
## 8. Appendix 1: population segmentation detail and methodology

### 2015/16 population size, total spend and spend per head by condition and age band

<table>
<thead>
<tr>
<th>Age</th>
<th>Most healthy</th>
<th>Chronic conditions</th>
<th>Serious and enduring mental illness</th>
<th>Dementia</th>
<th>Cancer</th>
<th>Severe physical disability</th>
<th>Learning disability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Thousands</td>
<td>Millions</td>
<td>£</td>
<td>Million</td>
<td>£</td>
<td>Million</td>
<td>Million</td>
</tr>
<tr>
<td>0-15</td>
<td>£405</td>
<td>£384</td>
<td>£13,095</td>
<td>£9,765</td>
<td>£2,894</td>
<td>£506</td>
<td>£1,170</td>
</tr>
<tr>
<td></td>
<td>328.7</td>
<td>17.1</td>
<td>1.3</td>
<td>0.2</td>
<td>tbc</td>
<td>0.5</td>
<td>£1,170</td>
</tr>
<tr>
<td>16-69</td>
<td>£496</td>
<td>£1,427</td>
<td>£19,672</td>
<td>£9,005</td>
<td>£15,535</td>
<td>£20,357</td>
<td>£112.2</td>
</tr>
<tr>
<td></td>
<td>903.7</td>
<td>297.1</td>
<td>8.0</td>
<td>23.6</td>
<td>6.7</td>
<td>5.5</td>
<td>112.2</td>
</tr>
<tr>
<td>70+</td>
<td>£939</td>
<td>£2,790</td>
<td>£9,040</td>
<td>£6,584</td>
<td>£16,295</td>
<td>£13,470</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80.6</td>
<td>107.6</td>
<td>1.2</td>
<td>10.8</td>
<td>22.1</td>
<td>0.4</td>
<td>£4.9</td>
</tr>
</tbody>
</table>

Notes: People registered to GP surgeries which flow into KID but had no activity in 2015/16 have been added to “mostly healthy” segments. Populations have been scaled to account for population registered to practices not flowing data into the KID. Spend has been scaled to match CCG data returns to account for data not included in the KID (e.g. CAMHS, non-PbR acute activity). Children’s social care, prescribing costs and continuing care costs are not included. Source: Kent Integrated Dataset; Carnall Farrar analysis; latest version as of 30/11/2016.

- Only patients registered to GP practices flowing data into the Kent Integrated Dataset (KID) have been used
- Patients have been assigned to segments depending on their age and health status
- Patients with zero associated spend or activity during 2015/16 have been assigned to the “mostly healthy” category
- Population has been scaled to meet 100% of each CCG’s population to account for those practices excluded from the KID
- Manual adjustments for some data not available from the KID (e.g. physical disabilities, CAMHS)
- Total spend across primary care, mental health, community, acute and social care services have been summed for each of the segments
- Spend has been scaled to 100% of spend by POD for each CCG to account for spend not included in the KID (e.g. non-PbR acute activity)
- Manual adjustments for some spend categories outside of the KID (e.g. physical disabilities, CAMHS) and apportionment of “other acute” spend across the population segments
- Breakdown by age and condition with population, total spend, spend per capita, and a breakdown of spend by POD
- Kent-wide segmentation complete
- Individual CCG segmentations almost complete
- Medway has been excluded as required primary care data is not included in the KID¹
- Child social care spend, continuing care spend and prescribing costs have been excluded²

Notes: ¹KID data has been scaled up to give an estimation for Medway
²These categories total £507m of spend across the seven Kent CCGs
Source: Kent Integrated Database, Carnall Farrar analysis
<table>
<thead>
<tr>
<th>CCG</th>
<th>Registered Population</th>
<th>With activity during 15/16</th>
<th>Without activity during 15/16</th>
<th>Total</th>
<th>Scaling Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashford</td>
<td>129,000</td>
<td>59,000</td>
<td>+ 46,000</td>
<td>105,000</td>
<td>1.23</td>
</tr>
<tr>
<td>Canterbury &amp; Coastal</td>
<td>220,000</td>
<td>115,000</td>
<td>+ 82,000</td>
<td>197,000</td>
<td>1.12</td>
</tr>
<tr>
<td>DG&amp;S</td>
<td>261,000</td>
<td>210,000</td>
<td>+ 31,000</td>
<td>241,000</td>
<td>1.08</td>
</tr>
<tr>
<td>SKC</td>
<td>202,000</td>
<td>112,000</td>
<td>+ 53,000</td>
<td>166,000</td>
<td>1.22</td>
</tr>
<tr>
<td>Swale</td>
<td>110,000</td>
<td>62,000</td>
<td>+ 15,000</td>
<td>77,000</td>
<td>1.44</td>
</tr>
<tr>
<td>Thanet</td>
<td>144,000</td>
<td>78,000</td>
<td>+ 39,000</td>
<td>117,000</td>
<td>1.23</td>
</tr>
<tr>
<td>West Kent</td>
<td>479,000</td>
<td>228,000</td>
<td>+ 106,000</td>
<td>333,000</td>
<td>1.44</td>
</tr>
<tr>
<td>Kent Total</td>
<td>1,556,000</td>
<td>864,000</td>
<td>+ 372,000</td>
<td>1,236,000</td>
<td>1.25</td>
</tr>
</tbody>
</table>

Note: Where figures are scaled to from Kent population to Kent and Medway population, a further scaling factor of 1.19 was applied.
Source: Kent Integrated Dataset, Carnall Farrar analysis.
9. Endnotes


3 This figure is not to be confused with 1,600 deaths which were amenable if healthcare was more timely and effective. 9,200 deaths were preventable if there were more effective public health interventions and is taken from the Public Health Outcomes framework.

4 Office for National Statistics, various years


6 Office for National Statistics, mid-year estimates 2015

7 CCG data, NHS England, Kent County Council, Medway Council

8 NHS Choices (2016), Kent and Medway NHS and Social Care Partnership Trust

9 Sussex Partnership NHS Foundation Trust (2016)

10 Provider data returns (2016); Carnall Farrar Analysis

11 Kent County Council (2016), Risk Summit Data Collection

12 Provider data returns, October 2016 (data from 15/16 year)

13 Google maps, recorded at 2pm on 24/10/16

14 Kent County Council (2016) “The Kent and Medway Growth and Infrastructure Framework (KMFIG) – September update”.


16 Office for National Statistics (2016) - 2011-2031 projection


21 CCG 2014/15 spend by POD; Carnall Farrar analysis


23 Kent and Medway provider length of stay data; NHSE KH03 occupancy data, 2015/16; KCC population growth estimates; Carnall Farrar analysis (estimated at current occupancy rates).

24 Kent Integrated Dataset (KID) (2015/16); Carnall Farrar Analysis


26 Department for Communities and Local Government (2015), Index of Multiple Deprivation by local authority; Office for National Statistics (2015), Life expectancy by local authority


29 Department for Communities and Local Government (2015), Index of Multiple Deprivation by local authority; Public Health England, Public Health Outcomes Framework (2013/14)


Quality and Outcomes Framework (QOF) 2014/15

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CQC (2017)

CQC (2015)


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Peer benchmark calculated as top quartile of activity rates of 10 closest CCG peers identified for each Kent and Medway CCG by NHS Right Care; NHS England (2016) Monthly Activity Return data (2015-16); NHS Right Care peers; Carnall Farrar analysis

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Public Health England – Cancer Outcomes: Stage at Diagnosis and Emergency Presentations (average of quarterly data FY2013)


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193 Health Education England (2016) Kent, Surrey and Sussex (KSS) GP Workforce Data Tool, September 2016 submission; Carnall Farrar analysis
194 Provider return (2016), Carnall Farrar analysis
195 HM Land Registry, 2015
197 Royal College of Paediatrics and Child Health (2013), Workforce census, published online 2013
200 Estates Returns Information Collection (ERIC) (2015/2016), HSCIC
201 Estates Returns Information Collection (ERIC) (2015/2016), HSCIC
202 Estates Returns Information Collection (ERIC) (2015/2016), HSCIC
203 East Kent combined property data file (2016)
204 Trust data (November 2016 for MCH and February 2018 for KCHFT), Carnall Farrar analysis