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Kent County Council

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ASHFORD HEALTH PROFILE

A health profile of the population that is covered by the Ashford Clinical Commissioning Group.

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EXECUTIVE SUMMARY

Changes or additions to the Ashford Health Profile Report from 2011 are highlighted.

Demographics

1. Ashford's population is ageing due to lower birth rates and higher life expectancy over the past few decades. This is a universal problem that many developed countries currently face. The implications for health services are: increasing need for health and social care for elderly people at home or in care homes, requiring more staff and more funding.

2. There is a large difference in life expectancy between electoral wards within Ashford and this is a strong indicator for the existence of health inequalities. CCGs need to ensure that access to NHS care is equitable across different groups.

Community

3. **Pupils in Ashford have a lower rate achieving GCSEs including English and Mathematics than pupils in England overall**. Evidence has shown that Sure Start children centres have positive effects on children abilities and visits should be encouraged. Healthy schools programmes have helped to promote good learning environments and need continued support.

4. **Homelessness in Ashford is high and homeless people have disproportionately more health problems than the general population**. Hospital services are used more frequently. Health needs of homeless people are currently not met and access to primary care and prevention programmes needs to improve.

Lifestyle

5. People living in deprived areas consume less fruit and vegetables. Public health programmes to encourage healthy eating have been rolled out in Ashford and should continue. NICE guidance suggests that small programmes targeted at high risk groups and longer interventions with a sound theoretical basis are most effective.

6. Adult obesity is a particular problem in Ashford. NICE recommends a combined approach, addressing diet and exercise. Group interventions are superior to individual interventions. Public Health interventions to reduce weight available for adult Ashford residents mainly consist of 1:1 appointments and commissioners may want to consider installing group level interventions in addition.

7. Smoking prevalence is highest in people from routine and manual occupations. NICE recommends a harm-reduction approach to reduce smoking prevalence which promotes cutting down and reducing cigarette consumption for those not able to stop abruptly. The use of licensed nicotine-containing products should be encouraged. The programme is expected to be rolled out in Kent in 2014.

Inequalities by population group

8. Young people:

    - Childhood obesity is a significant problem with rates of around 19% in Ashford. A variety of Public Health Programmes are currently running focusing on weight reduction in children. Support for these programmes

should continue together with monitoring that the correct target groups are reached.

- Teenage pregnancy rates have been falling but are high in areas of high deprivation. Effective interventions include school-based SRE (sex and relationship education) linked to contraceptive services and Youth Development Programmes. SRE is currently provided within the Healthy Schools Programmes. Initiatives like HOUSE for young people, started in 2011, also offer advice and aim to reach high risk groups.

9. Maternity:

    - **Smoking during pregnancy is a problem in Ashford with rates significantly higher than the England average.** NICE has published guidance on this topic and suggests cognitive behaviour therapy, motivational interviewing, structured self-help and support from NHS Stop Smoking Services. CO testing by midwifes is recommended and all staff (midwifes, smoking advisors, etc) should have appropriate training and know to ask questions in a way that women speak openly about their smoking status.

    - **Breast feeding initiation rates in Ashford are low.** It is important to educate women on the positive effects of breastfeeding, either in group sessions or 1:1. Promotions delivered over both the ante- and postnatal period have been shown to be beneficial.

10. Older people

    - **Rates of hip fractures are high in some electoral wards in Ashford.** Access to Falls Prevention Services for elderly residents needs to be ensured with a focus on wards with high hip fracture prevalence.

Use of Health Services

11. Emergency admissions in Ashford are comparatively lower than in the rest of Kent. It is important that commissioners are aware of what types of admissions are avoidable and how to prevent them. Encouraging self-management of people with Long Term Conditions and good access to primary care including out-of-hours are important.

12. Vaccination uptake rates in Ashford practices are good with most reaching the WHO target of 95% or more.

13. **Not all practices in Ashford are achieving national targets in screening uptake and inequalities in uptake by deprivation quintile have been shown.** Practices serving more deprived populations may need to be more active to increase uptake. Efforts should be made to encourage attendance in those who have never participated in screening and economic barriers should be reduced. Healthcare professionals could use reminder systems such as tagged notes.

Long Term Conditions

14. Long Term Conditions are expected to increase as the population structure gets increasingly older. **There are large variations in prevalence by GP practice suggesting a risk of under diagnosis in some population groups.** Case finding is important in order to target prevention programmes to the appropriate population groups.

15. The focus for people with long term conditions should be on self-care but with appropriate services and equipment available to support patients and their carers.

Ashford's plans for expansion

16. The **population in Ashford is expected to grow rapidly** over the next few years as a number of new developments are in the planning stage. Public health issues are: i) to ensure good access to primary care with enough capacity to include new residents in preventative health programmes; ii) to encourage physical activity and design new built areas with community spaces, safe roads and cycle lanes; and iii) to promote healthy eating by making fresh food available locally and give space for own produce/community gardens.
    A careful design of new developments will encourage the development of social cohesion and have positive influences on people with mental health problems.

1 INTRODUCTION

1.1 HEALTH AND SOCIAL CARE ACT

Clinical Commissioning Groups (CCGs) were set up under the Health and Social Care Act 2012 and became functional on 1st April 2013. CCGs have responsibilities to commissioning health services for the local area. Duties of CCGs are specified in the Health and Social Care Act and include the duty to

(a) Reduce inequalities between patients with respect to their ability to access health services, and
(b) Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

1.2 INEQUALITIES IN HEALTH

The review on health inequalities in England published by Michael Marmot in 2010: “Fair Society, Healthy Lives” gives the key message that “the fact that in England today people in different social circumstances experience avoidable differences in health, well-being and length of life is, quite simply, unfair…Taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole society.”

In the report recommendations it is highlighted that “reducing health inequalities will require action on six policy objectives:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups.”

Under the NHS reconfiguration, CCGs work closely together with local hospitals, Public Health and the Local Authority. Reducing health inequalities in society is a joint effort and concerns not just health service provision but includes the physical, social and economic environment.

1.3 THE ROLE OF CCGS

With the duty of reducing inequalities in health in the local population, one focus for commissioners should be, in line with Michael Marmots recommendations, on ill-health prevention.

1.3.1 PRIMARY PREVENTION

Illness is often preventable and differences in health behaviour are a major contributing factor to inequalities in health. It is important to invest into preventative programmes such as healthy nutrition advice, exercise classes, stop smoking support, falls prevention etc. The delivery of prevention programmes needs to be equitable so that no population groups are disadvantaged in access and outcomes.

1.3.2 SECONDARY PREVENTION

A number of screening programmes have been rolled out over recent years in order to detect and treat disease at an early stage, therefore reducing the demand on resources at more advanced stages and improve outcomes. Some cancers are curable when detected early and complications of cardiovascular disease and diabetes can be avoided when timely treatment and health advice is given.

It is important to further promote active case finding through health checks and screening programmes and to raise awareness of early disease symptoms within the population so that disease presentation is at an early stage.

1.3.3 TERTIARY PREVENTION

Long term conditions are a concern with much pressure on health care systems. Frequent use of health services are an indication that individuals are often not supported sufficiently in the community. Investments should be made into support programmes that help people with disabilities to cope with their illness, to gain higher degrees of independence and to improve quality of life.

1.4 AIM OF THIS REPORT

This report on the Ashford Health Profile has two main tasks:

1. To report characteristics of the population within the Ashford CCG, highlighting specific needs for CCGs to incorporate in commissioning decisions and future planning.
2. To show changes that have occurred since the last health profile was undertaken in 2011.

2 METHODS

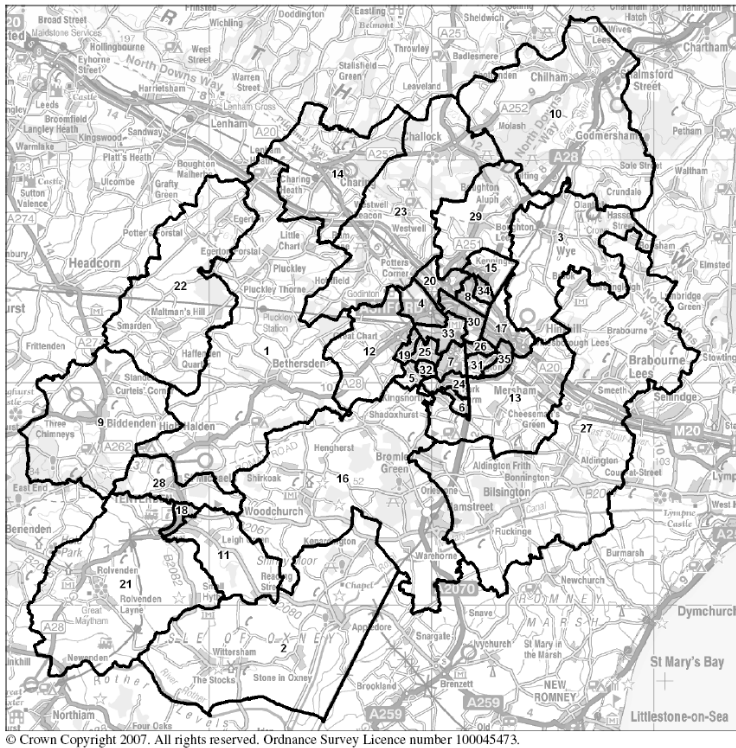
Information was collected from the Kent & Medway Public Health Observatory, the Network of Public Health Observatories (APHO) website, now part of Public Health England, from the Health & Social Care Information Centre website (NCHOD) and from the Office for National Statistics (ONS).

3 DEMOGRAPHICS

3.1 GEOGRAPHY

There are seven Clinical Commissioning Groups (CCGs) in Kent: (i) Ashford, (ii) Canterbury & Coastal, (iii) Dartford, Gravesham & Swanley, (iv) South Kent Coast, (v) Swale, (vi) Thanet and (vii) West Kent. Ashford CCG boundaries are based on Ashford LA electoral wards (Figure 1), but two wards (Biddenden and Weald North) are covered by West Kent CCG and one ward (Downs North) is covered by Canterbury CCG (Figure 2). There are 16 GP practices in the Ashford CCG area, distributed as seen in Figure 3.

Key to Electoral Wards in Ashford LA



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No.	Ward Name
1	Weald Central
2	Isle of Oxney
3	Wye
4	Godinton
5	Washford
6	Park Farm South
7	Norman
8	Bybrook
9	Biddenden
10	Downs North
11	Tenterden South
12	Great Chart With Singleton North
13	Weald East
14	Charing
15	Kennington
16	Weald South
17	North Willesborough
18	Tenterden North
19	Singleton South
20	Bockhanger
21	Rolvenden and Tenterden West
22	Weald North
23	Downs West
24	Park Farm North
25	Beaver
26	Aylesford Green
27	Saxon Shore
28	St. Michaels
29	Boughton Aluph and Eastwell
30	Stour
31	South Willesborough
32	Stanhope
33	Victoria
34	Little Burton Farm
35	Highfield

Figure 1: Electoral Wards in Ashford LA

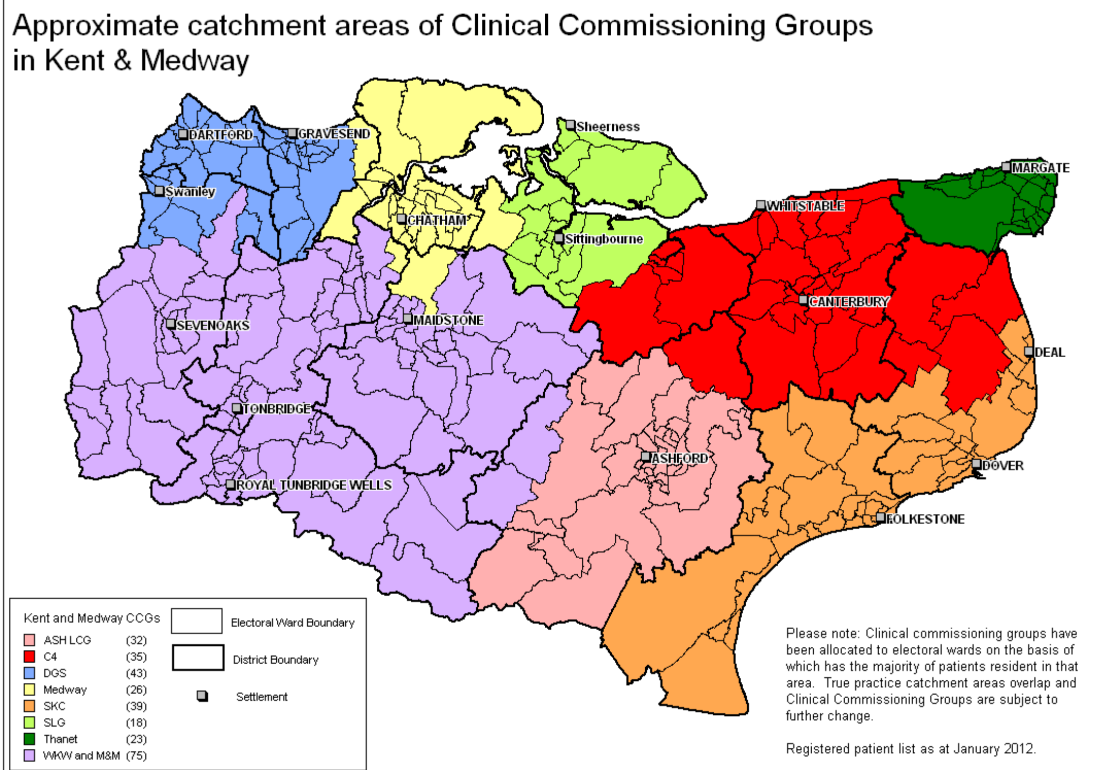
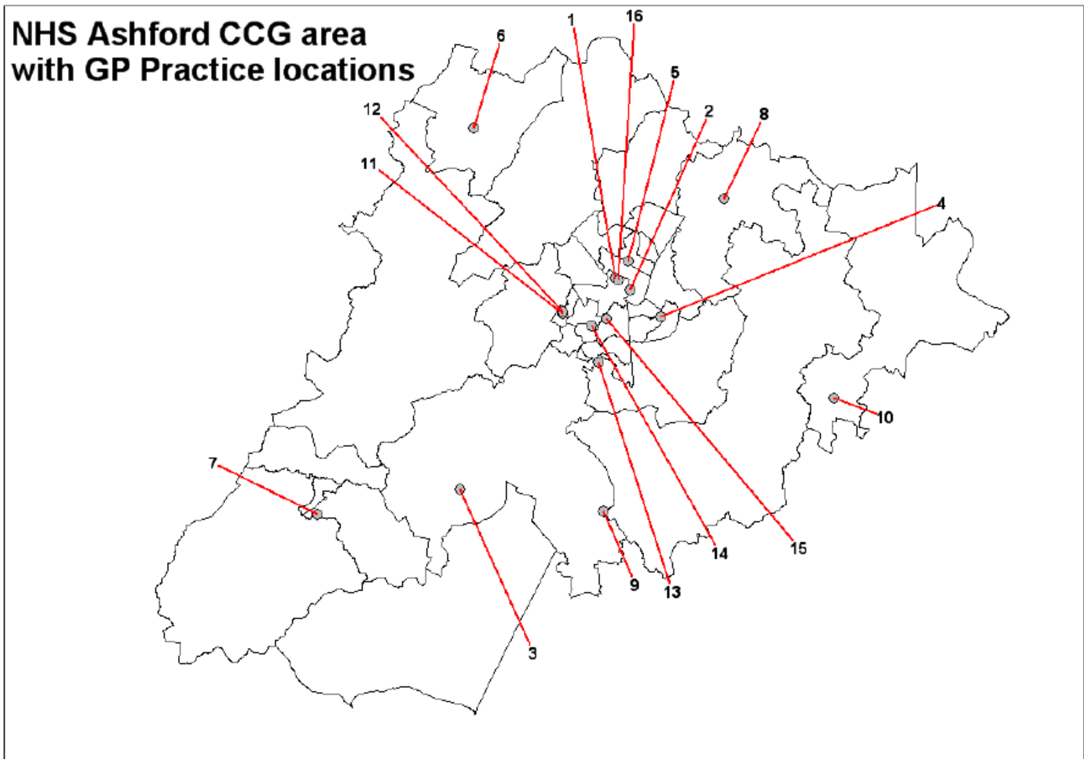


Figure 2: Clinical Commissioning Groups catchment areas



Key	Practice	Practice name
1	G82049	Dr Mohammed Y I
2	G82050	Sydenham House Medical Centre
3	G82053	Dr Busk C M A & Partner
4	G82080	Dr Cooney J A F & Partners
5	G82087	Dr Diu R S & Partners
6	G82094	The Charing Surgery
7	G82114	Dr Lloyd-Smith A R & Partners
8	G82142	Dr Waller R & Partners
9	G82186	Dr Lai A K T & Partner
10	G82658	Dr Del Bianco G & Partner
11	G82688	Dr Setty M V S
12	G82712	Dr Thomas A
13	G82730	Dr Kelly J C & Partners
14	G82735	St Stephens Health Centre
15	G82748	Dr Fernandes M A A
16	G82788	Dr Pinnock R G

Figure 3: GP practice locations in Ashford

3.2 POPULATION SIZE AND STRUCTURE

3.2.1 CURRENT POPULATION

The 16 GP practices within the Ashford CCG serve a population of 120,116 (ONS, mid-year estimates 2012). The population pyramid shows graphically the distribution of age groups in a population. The distribution of the Ashford CCG population can be classified as a "constrictive" pyramid, meaning that there are lower numbers of young people and larger numbers in the age ranges between 40 and 69. This type of age structure is often referred to as the "ageing population time bomb". The shift in age structure towards older people with a simultaneous reduction in working-aged adults has implications on future pensions, provision of health and social care and economic growth.

In comparison to England, Ashford has a considerably smaller proportion of 20 to 34 year olds and a larger proportion of 40-49 and 60+ year olds.

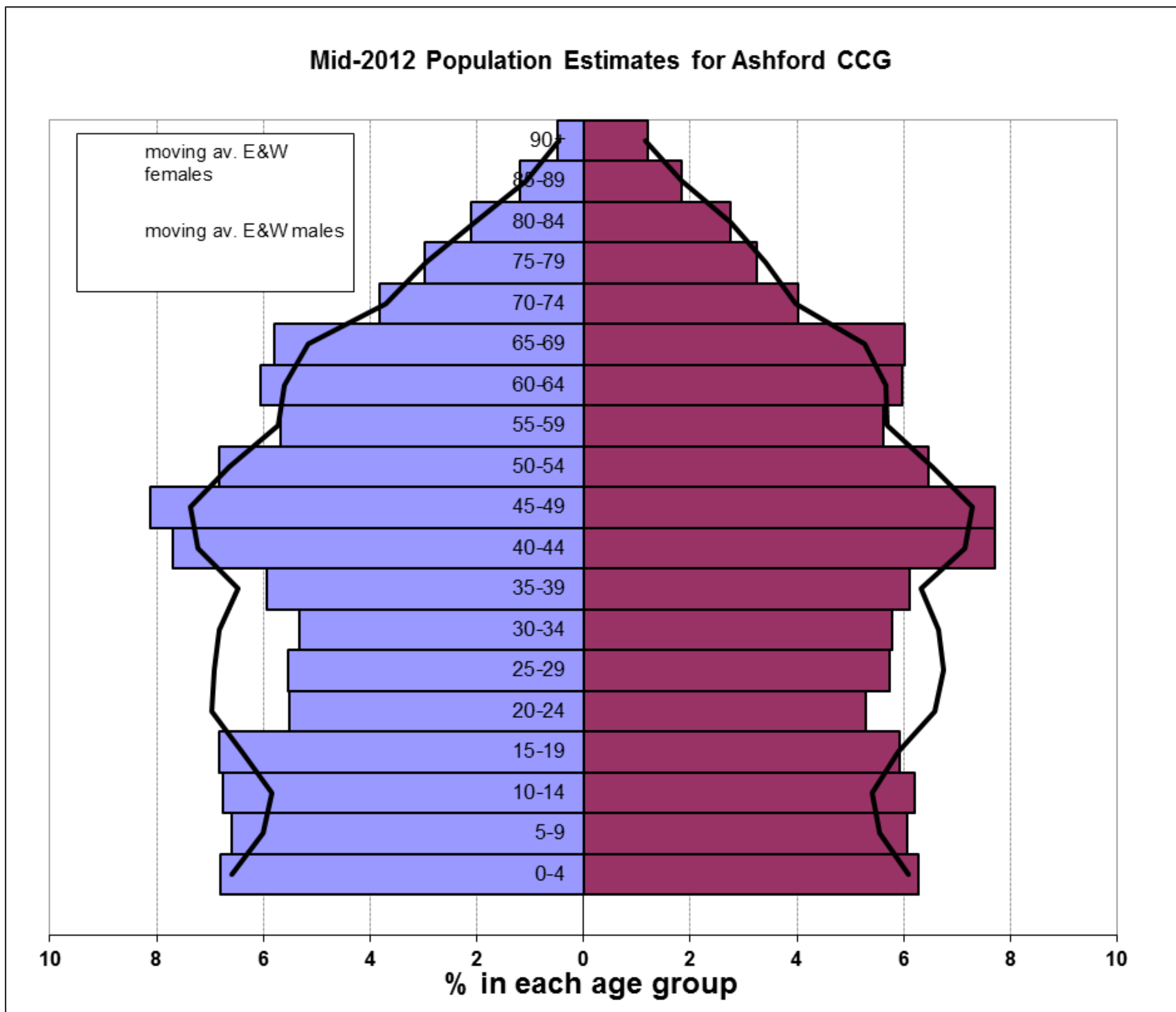
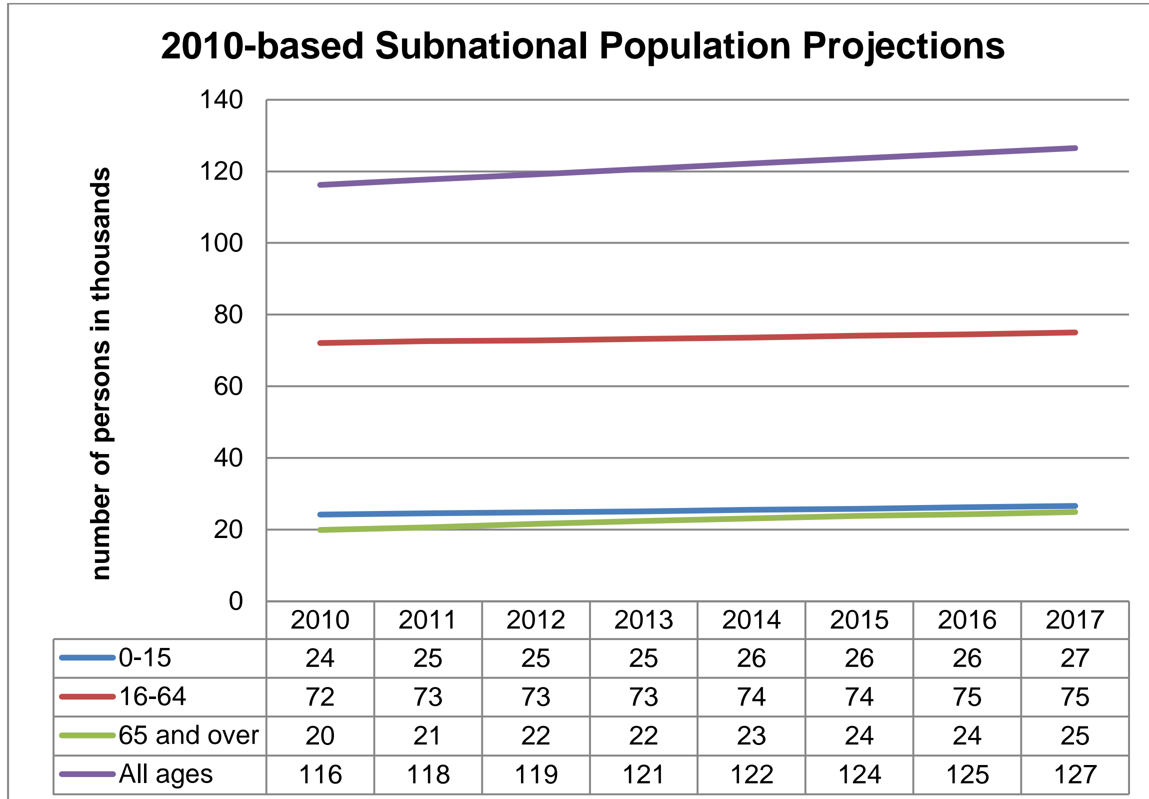


Figure 4: Population pyramid for Ashford CCG

3.2.2 POPULATION PROJECTIONS

Population projections are carried out by the Office for National Statistics (ONS) for the whole of the UK and also for regions and Local Authorities. Future population size and structure is calculated based on future trends in fertility, mortality and migration.

The population in Ashford is predicted to increase over the next few years with the largest percentage increase expected in the 65+ year age group (20,000 in 2010 to 25,000 in 2017 = 25%).

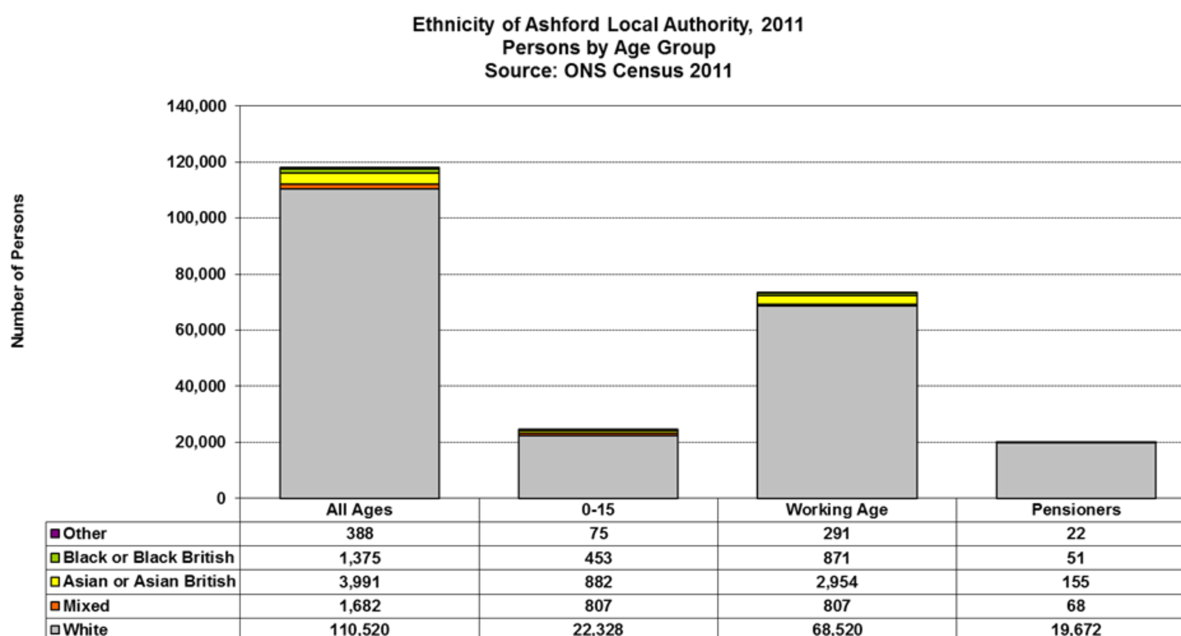


	2010	2011	2012	2013	2014	2015	2016	2017
0-15	24	25	25	25	26	26	26	27
16-64	72	73	73	73	74	74	75	75
65 and over	20	21	22	22	23	24	24	25
All ages	116	118	119	121	122	124	125	127

Figure 5: Population projections for Ashford LA

3.3 ETHNICITY

The ethnic majority in Ashford is White British (estimated 110,520 people compared to 7,436 people in BME groups). The highest percentage of BME groups is in those of working age (9.0%) and the lowest percentage is in pensioners (1.5%).

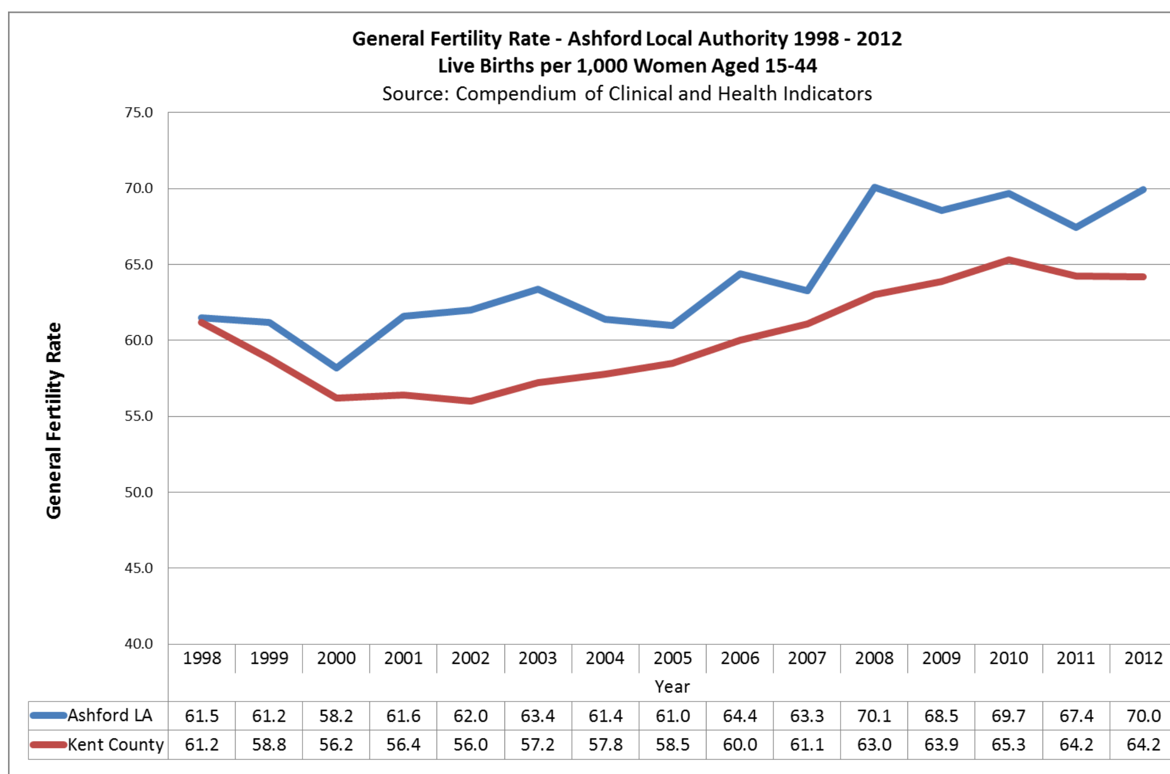


	All Ages	0-15	Working Age	Pensioners
Other	388	75	291	22
Black or Black British	1,375	453	871	51
Asian or Asian British	3,991	882	2,954	155
Mixed	1,682	807	807	68
White	110,520	22,328	68,520	19,672

Figure 6: Black and Minority Ethnic Groups in Ashford by age group

3.4 FERTILITY

The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15-44 per year. In Ashford, the GFR has increased from 2000 to 2008 but seems fairly stable at around 70/1000 live births per year from 2008 onwards (Figure 7). The GFR in Kent overall is lower than the Ashford rate.



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Ashford LA	61.5	61.2	58.2	61.6	62.0	63.4	61.4	61.0	64.4	63.3	70.1	68.5	69.7	67.4	70.0
Kent County	61.2	58.8	56.2	56.4	56.0	57.2	57.8	58.5	60.0	61.1	63.0	63.9	65.3	64.2	64.2

Figure 7: General Fertility Rate over time for Ashford LA

The highest GFRs are found in the electoral wards of Stanhope, Singleton South and South Willesborough. Lowest rates are in Saxon Shore, St Michaels and Charing (Figure 8).

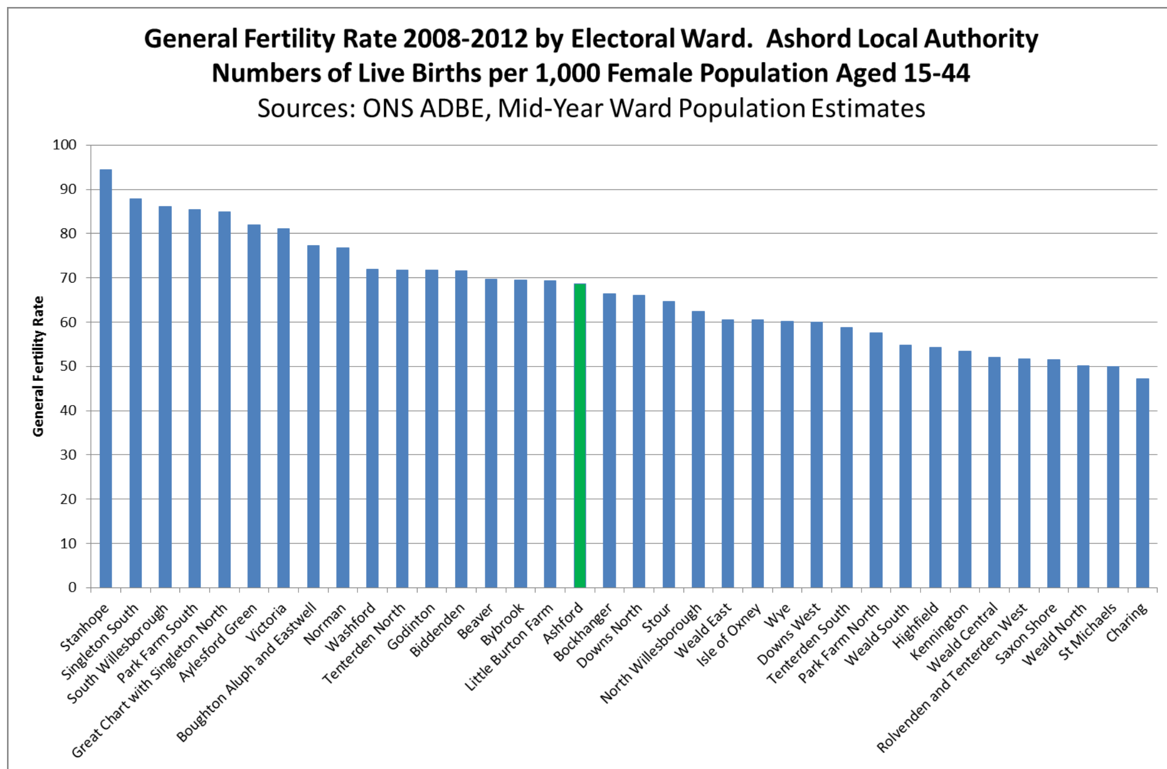


Figure 8: General Fertility Rate by electoral ward in Ashford LA

3.5 LIFE EXPECTANCY

Life expectancy can be defined as a "median" survival time in years from birth or a given age, meaning the number of years until 50% of a certain age-group has died. Life expectancy has generally improved over the last decades but improvements have been shown to vary by socio-economic group.

In Ashford, life expectancy ranges from 93.5 years in Park Farm North to 77.8 years in Weald North (Figure 9).

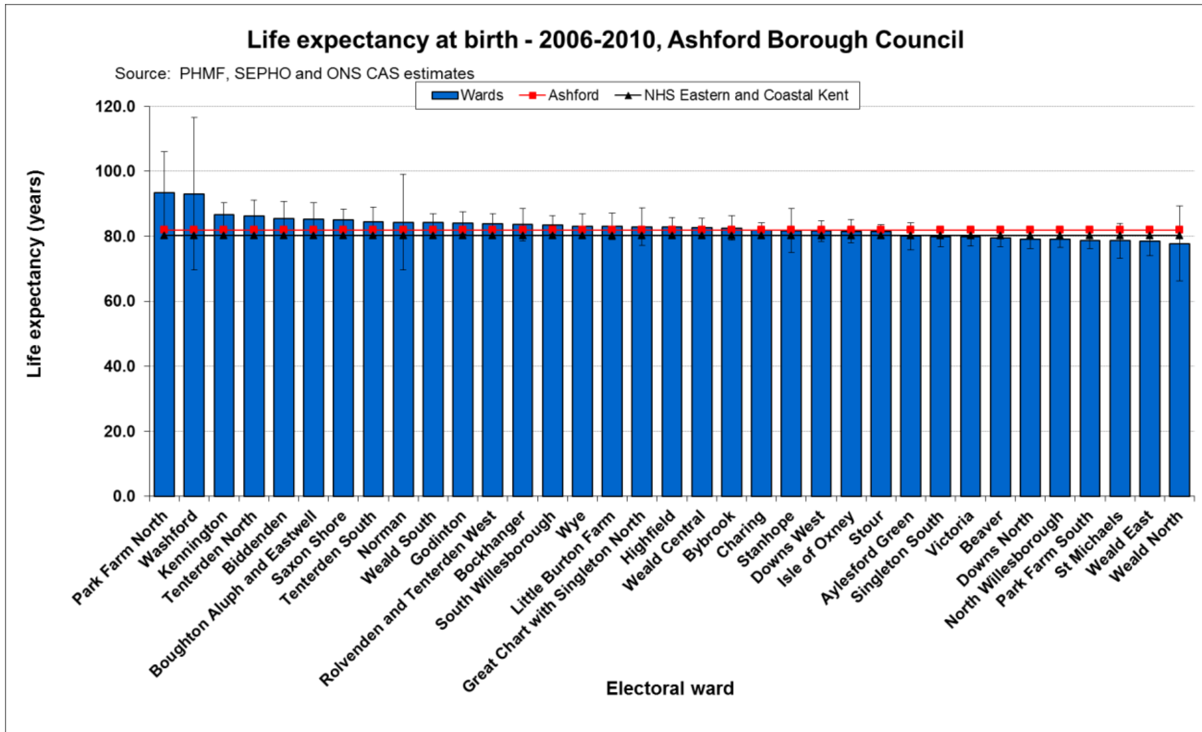
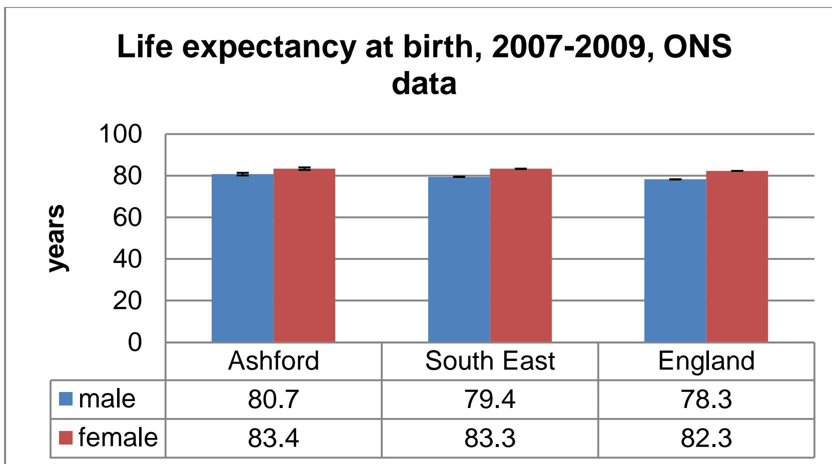


Figure 9: Life expectancy at birth by electoral ward for Ashford LA

Average life expectancy in Ashford is comparable to life expectancy in the South East and in England (Figure 10).



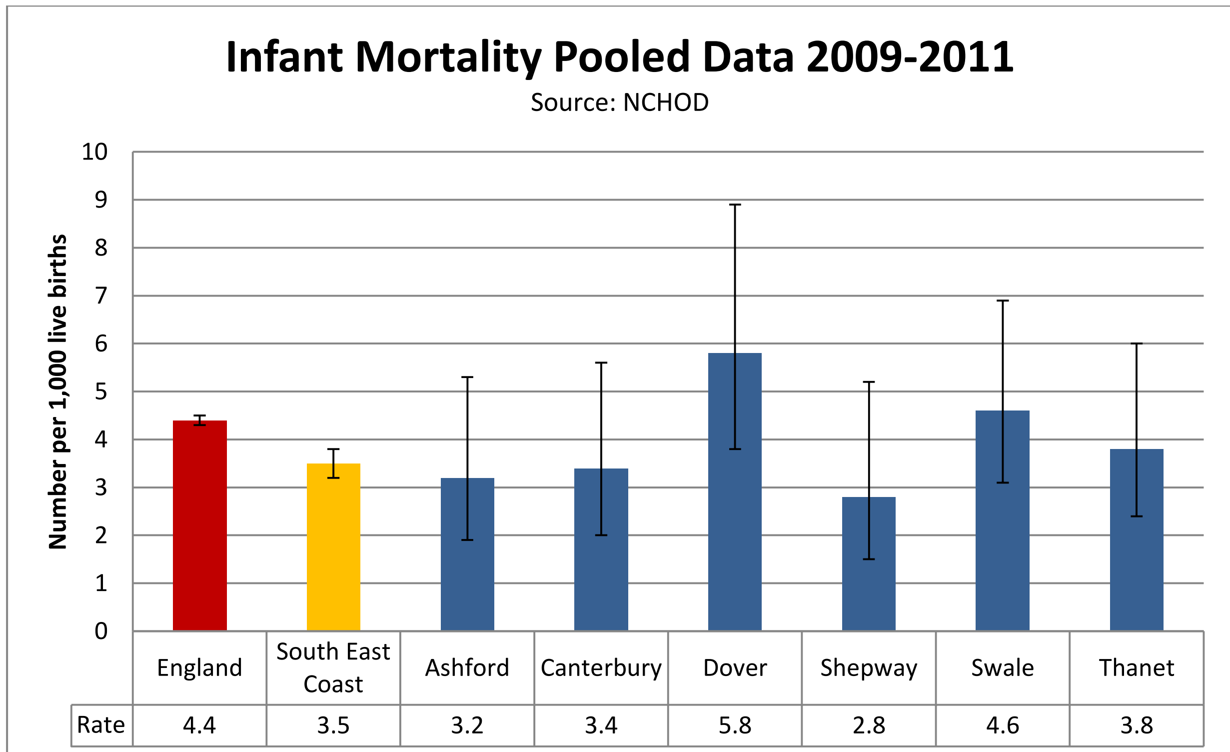
	Ashford	South East	England
male	80.7	79.4	78.3
female	83.4	83.3	82.3

Figure 10: Ashford LA life expectancy in comparison to the South East and England

3.6 INFANT MORTALITY

Infant mortality is defined as the number of deaths in infants, aged one year and younger, per 1,000 live births. It is seen as a key indicator of the overall health of a society because the majority of these deaths are preventable.

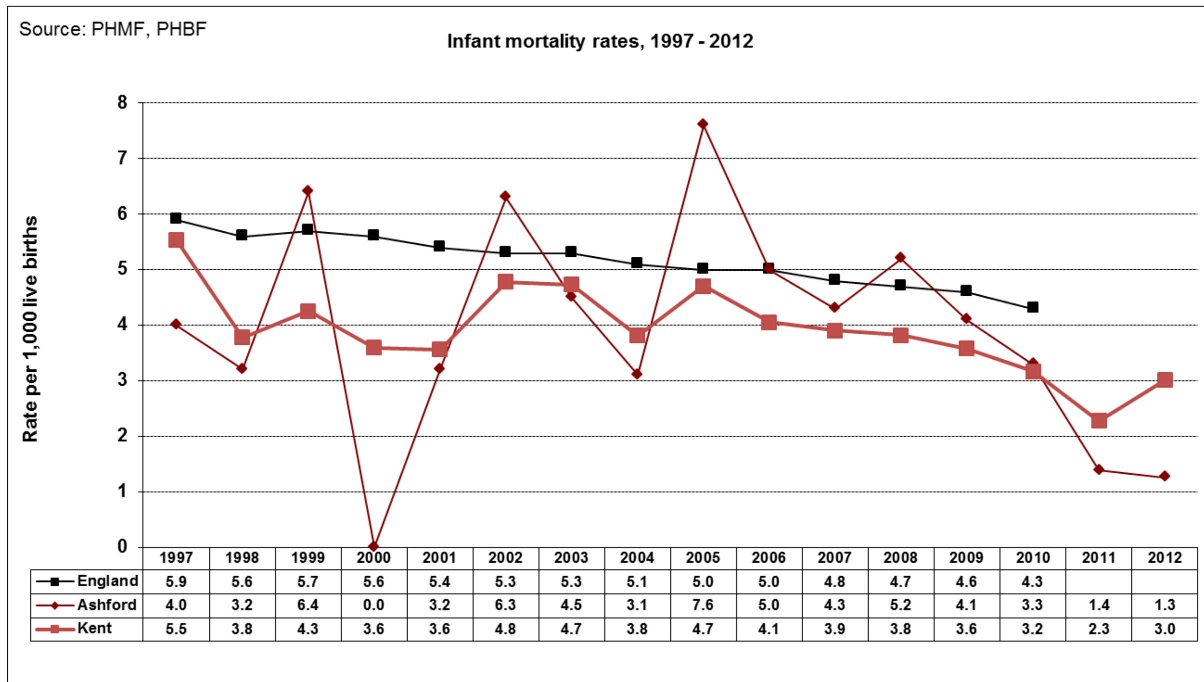
The infant mortality rate for Ashford was 3.2 deaths per 1,000 live births in 2009-2011 (pooled data). This compares to 4.4 deaths/1,000 in England and 3.5 deaths/1,000 in the South East Coast area (Figure 11).



	England	South East Coast	Ashford	Canterbury	Dover	Shepway	Swale	Thanet
Rate	4.4	3.5	3.2	3.4	5.8	2.8	4.6	3.8

Figure 11: Infant mortality rates in Ashford compared to areas in Kent and nationally

Overall, infant mortality rates have been decreasing continuously over time, in Ashford as well as nationally (Figure 12).



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
England	5.9	5.6	5.7	5.6	5.4	5.3	5.3	5.1	5.0	5.0	4.8	4.7	4.6	4.3		
Ashford	4.0	3.2	6.4	0.0	3.2	6.3	4.5	3.1	7.6	5.0	4.3	5.2	4.1	3.3	1.4	1.3
Kent	5.5	3.8	4.3	3.6	3.6	4.8	4.7	3.8	4.7	4.1	3.9	3.8	3.6	3.2	2.3	3.0

Figure 12: Infant mortality rates over time in Ashford, Kent and England

3.7 MORTALITY CAUSES

The main cause of death in Ashford is from circulatory causes, followed by cancer and then respiratory disease.

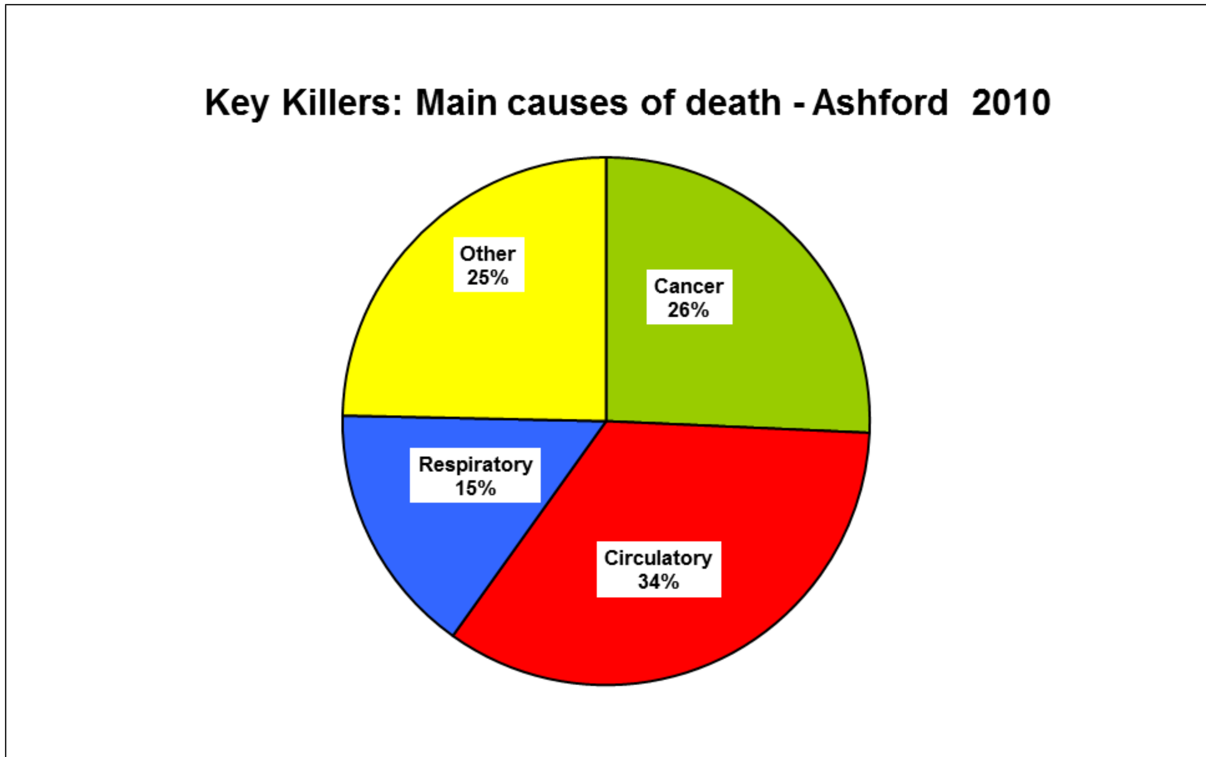
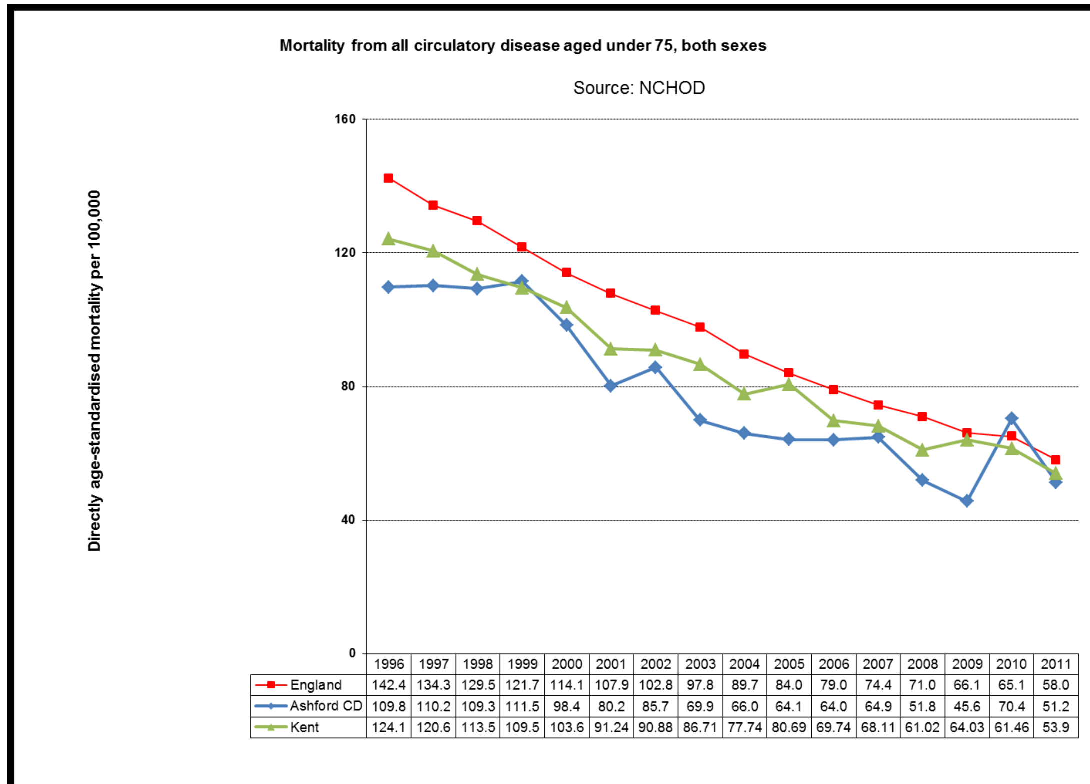


Figure 13: Causes of death, Ashford

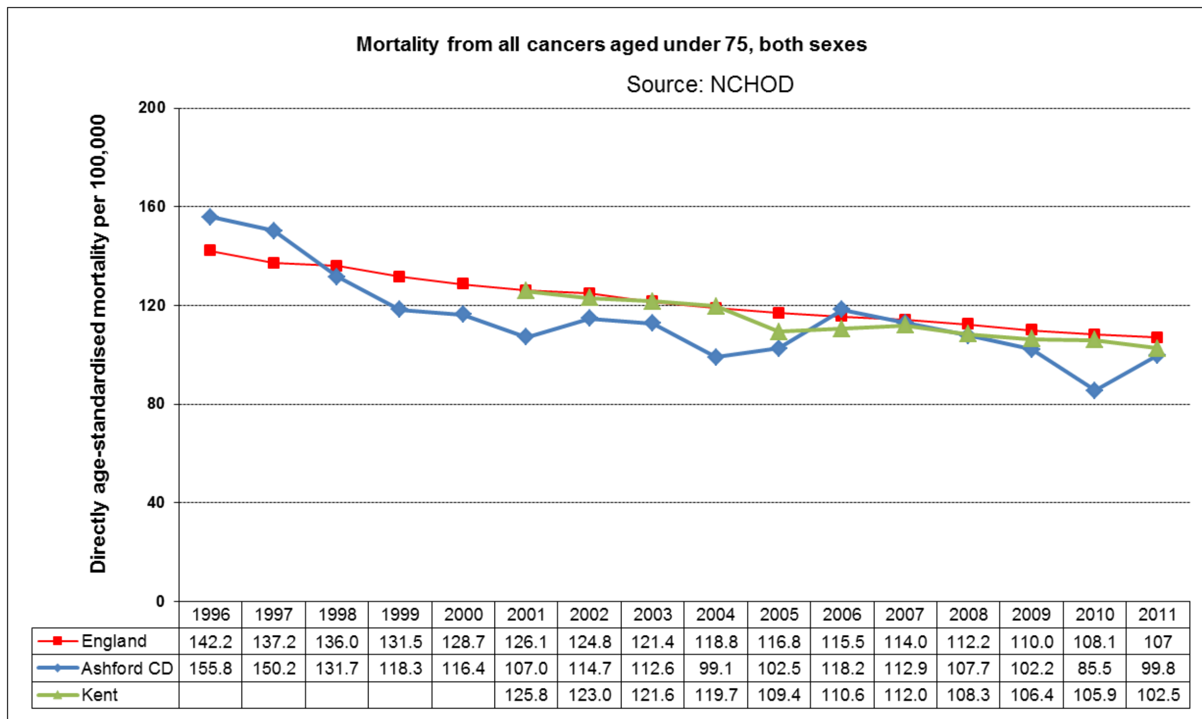
Death from circulatory disease has been decreasing steadily in Ashford from about 110/100,000 deaths in 1996 to 51/100,000 deaths in 2011. This trend is seen across England.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
England	142.4	134.3	129.5	121.7	114.1	107.9	102.8	97.8	89.7	84.0	79.0	74.4	71.0	66.1	65.1	58.0
Ashford CD	109.8	110.2	109.3	111.5	98.4	80.2	85.7	69.9	66.0	64.1	64.0	64.9	51.8	45.6	70.4	51.2
Kent	124.1	120.6	113.5	109.5	103.6	91.24	90.88	86.71	77.74	80.69	69.74	68.11	61.02	64.03	61.46	53.9

Figure 14: Mortality from circulatory disease over time

Mortality from cancer has also decreased, from 156/100,000 deaths in 1996 to 100/100,000 deaths in 2011. Again, a similar trend is observed for the whole of England.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
England	142.2	137.2	136.0	131.5	128.7	126.1	124.8	121.4	118.8	116.8	115.5	114.0	112.2	110.0	108.1	107
Ashford CD	155.8	150.2	131.7	118.3	116.4	107.0	114.7	112.6	99.1	102.5	118.2	112.9	107.7	102.2	85.5	99.8
Kent						125.8	123.0	121.6	119.7	109.4	110.6	112.0	108.3	106.4	105.9	102.5

Figure 15: Mortality from cancer over time

Public Health Interventions and Recommendations:

- Ashford has an "ageing" population structure and population projections predict further population increases disproportionately in older age groups over the next years. This has implication on the provision of health care and social care at home or in care homes with increasing needs for staff and funding in the future. Plans need to be in place on how the demand will be met.

- The General Fertility Rate (GFR) has been stable and similar to the England average over the last few years. There are, however, geographical pockets within Ashford where GFRs are high: Stanhope Ward, Singleton South Ward and South Willesborough Ward. There will be a higher demand for maternity services, health visitors and nurseries/schools in these areas.

- Life expectancy in Ashford is similar to national figures but the maximum gap between electoral wards is over 15 years difference. This is a strong indicator for the existence of health inequalities. Kent County Council has published an action plan: MIND THE GAP that includes strategies and targets to reduce inequalities in Kent[1]. CCGs need to ensure that access to NHS care is equitable across different groups: "*Emphasis on reducing inequalities should be focused on delivering screening and prevention programmes including Health Checks, immunisations, early diagnosis and reducing the burden of Long Term Conditions to the right populations not just those that present themselves.*"

- The main cause of death in Ashford is from circulatory disease, followed by cancer and respiratory disease. Mortality from circulatory disease and from cancer has been decreasing since 1996. This is an encouraging observation and the aim should be to maintain this trend of reducing avoidable deaths. Equitable access to relevant prevention programmes needs monitoring, particularly stop smoking services, cancer screening programmes and NHS health checks.

[1] http://www.kmpho.nhs.uk/easysiteweb/getresource.axd?assetid=228636&type=0&servicetype=1

4 COMMUNITY

4.1 DEPRIVATION

Deprivation is presented based on national quintiles of the Index of Multiple Deprivation (IMD) 2010 by Lower Super Output Area (LSOA). LSOAs are small geographical areas of relatively even size (around 1,500 people). There are 32,482 of these areas in England. The Index of Multiple Deprivation is derived from seven distinct domains: Income Deprivation, Employment Deprivation, Health Deprivation and Disability, Education Skills and Training Deprivation, Barriers to Housing and Services, Living Environment Deprivation, and Crime. Using appropriate weights, measures from these domains are combined which allows each geographical area in England to be ranked according to deprivation experienced.

The graph shows the England deprivation quintiles and in comparison the percentage of the population of each deprivation quintile living in the local area.

In Ashford, over 75% of people live in the middle three quintiles with 20% living in the most affluent quintile and only 5% in the most deprived quintile.

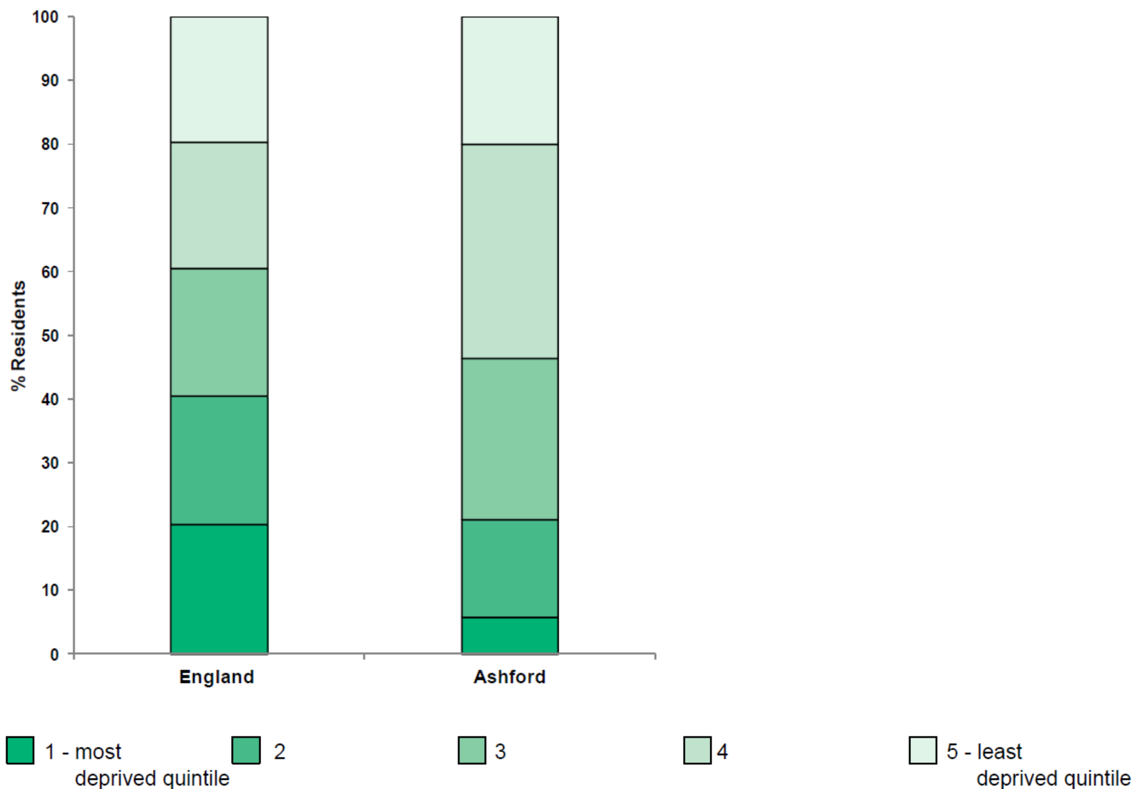


Figure 16: Deprivation quintiles in Ashford, 2013

Geographically, the most deprived areas in Ashford are: Stanhope Ward, Beaver Ward, Victoria Ward, Downs West Ward, Bockhanger Ward, Aylesford Green Ward and Norman Ward (Figure 17)

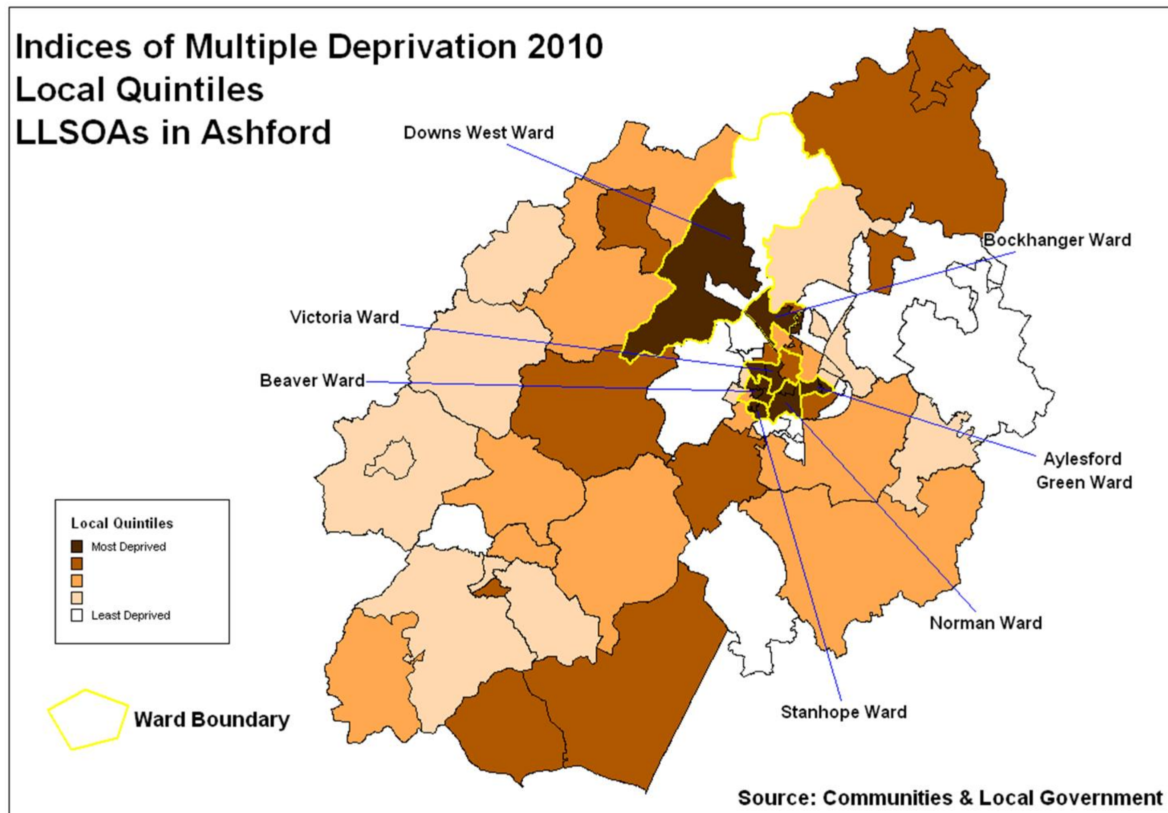


Figure 17: Deprivation in Ashford by electoral ward

The yellow lines demarcate those wards in Ashford within which most deprivation is experienced.

Deprivation is linked to overall health and life expectancy. This is illustrated in Figure 18, which was published in the Michael Marmot review: “Fair Society, Healthy Lives”. Awareness of where the local areas of high deprivation are, is essential in order to know where need is greatest. Areas of higher deprivation will require more resources and investments for an overall reduction in inequalities in health.

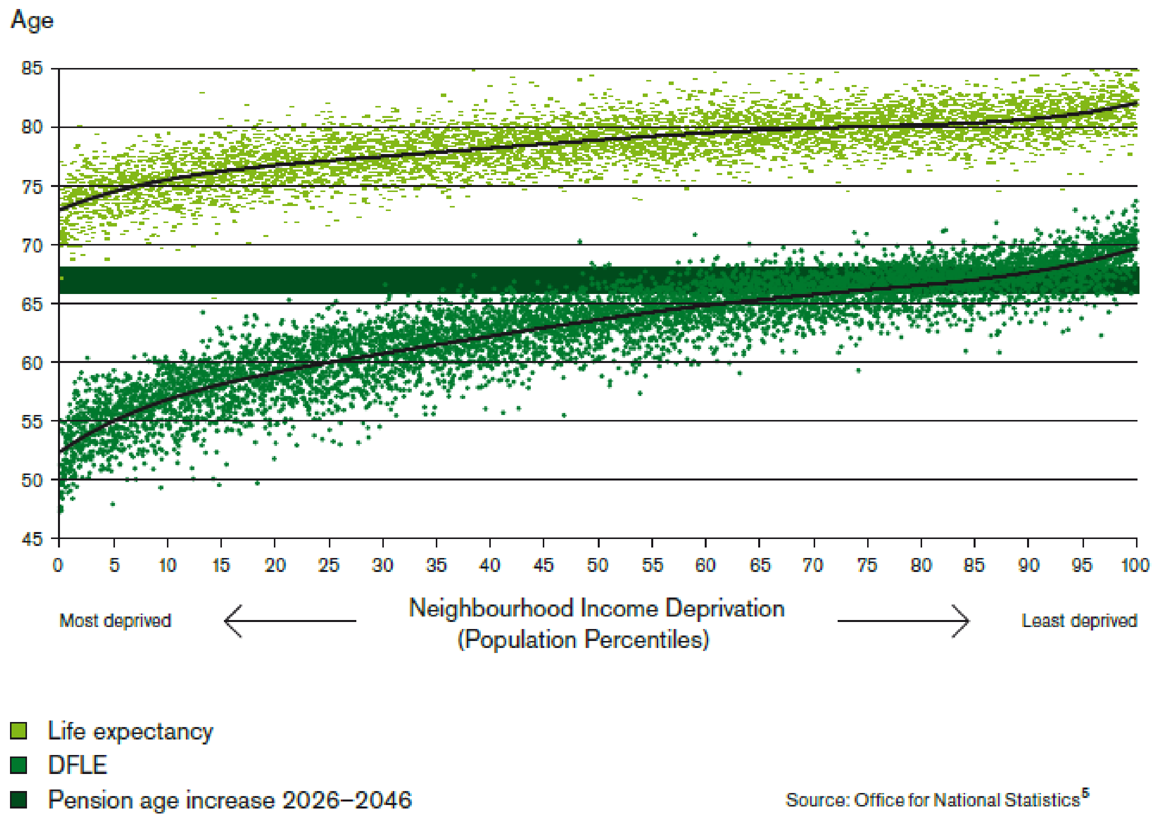


Figure 18: Relationship between deprivation and health/life expectancy

4.2 INCOME DEPRIVATION

Workers in Kent and the South East generally have a higher median income than workers in England as a whole (Figure 19). Within Kent, earnings are highest in Canterbury, followed by Ashford.

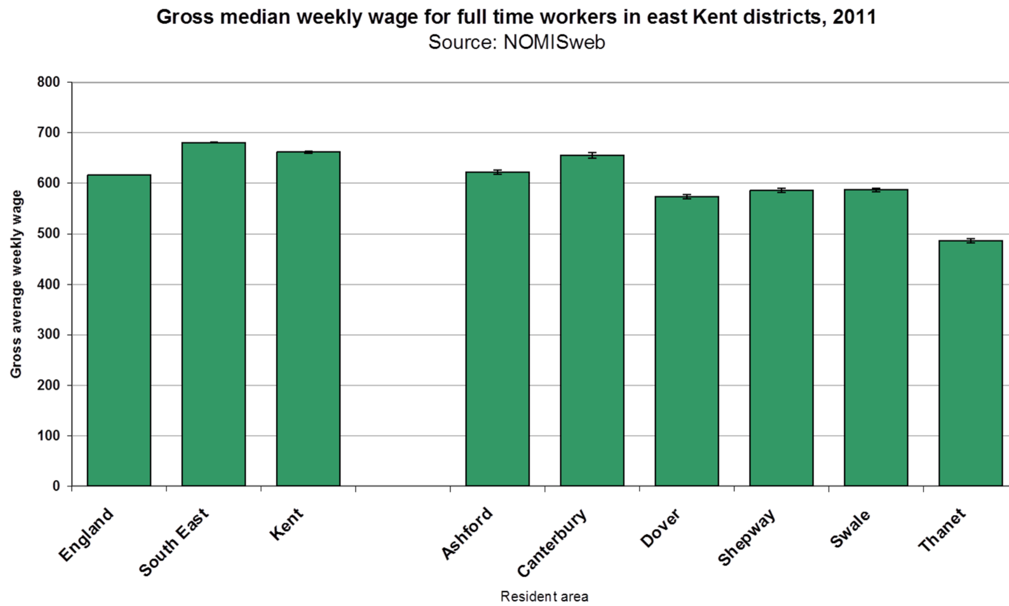


Figure 19: Income for full time workers in areas of Kent, compared to England

Still, there are pockets of income deprivation within Ashford and these are mainly in workers who live in Stanhope Ward, Beaver Ward, Victoria Ward, Charing Ward, Downs West Ward, Wye Ward, Bockhanger Ward, Aylesford Green Ward and Norman Ward (Figure 20).

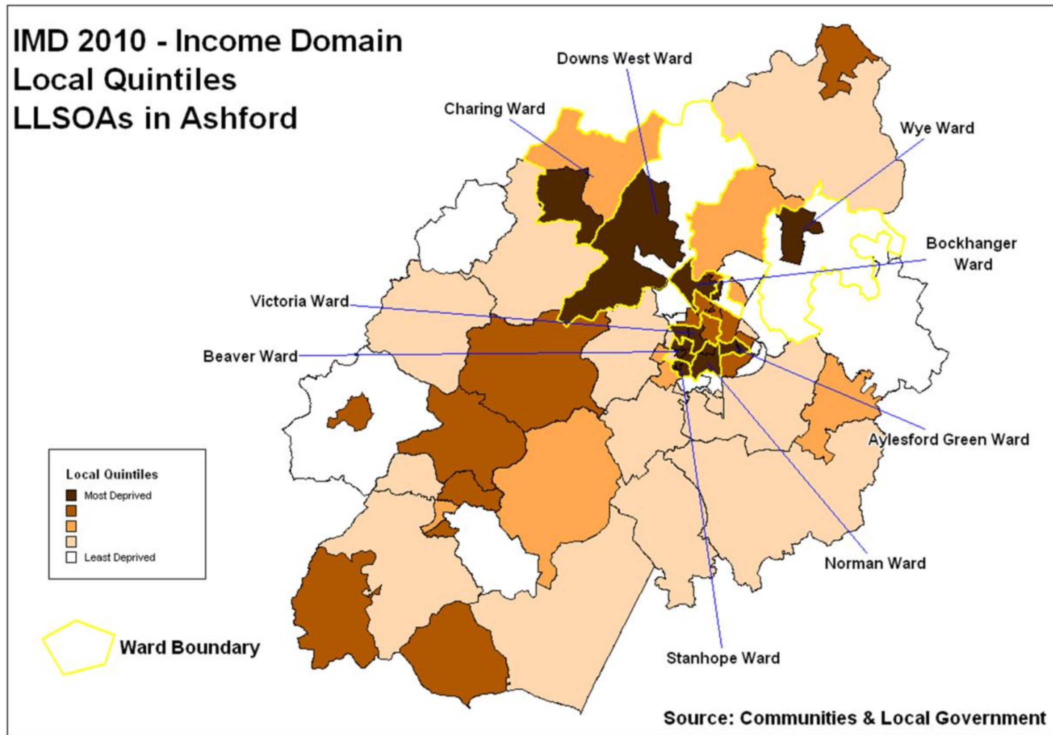


Figure 20: Income deprivation in Ashford by electoral ward

4.3 EMPLOYMENT DEPRIVATION

The unemployment rate in Ashford was 2.8% (number of resident population 16-64 years) in 2011 and this was below the Kent average of 3.1% and below the rate for England at 3.7% (Figure 21).

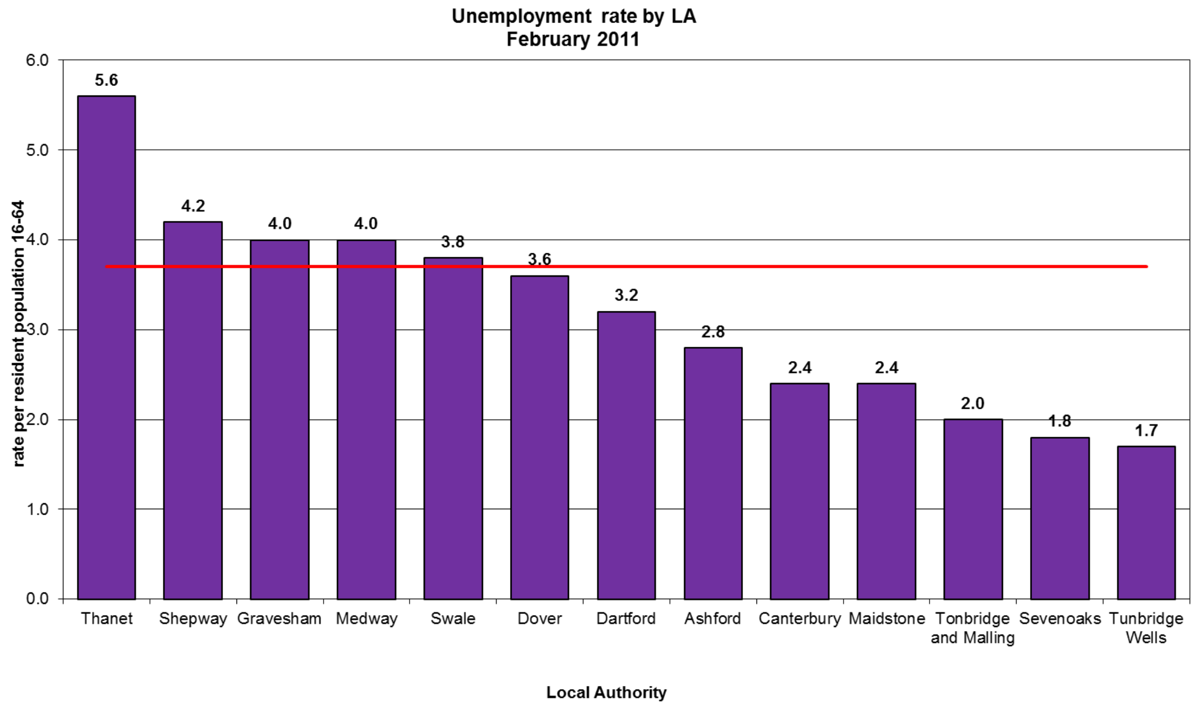


Figure 21: Unemployment rates in Kent Local Authorities compared to England

Wards with highest employment deprivation in Ashford are: Stanhope Ward, Beaver Ward, Victoria Ward, Godington Ward, Charing Ward, Downs West Ward, Bockhanger Ward, Aylesford Green Ward and Norman Ward (Figure 22).

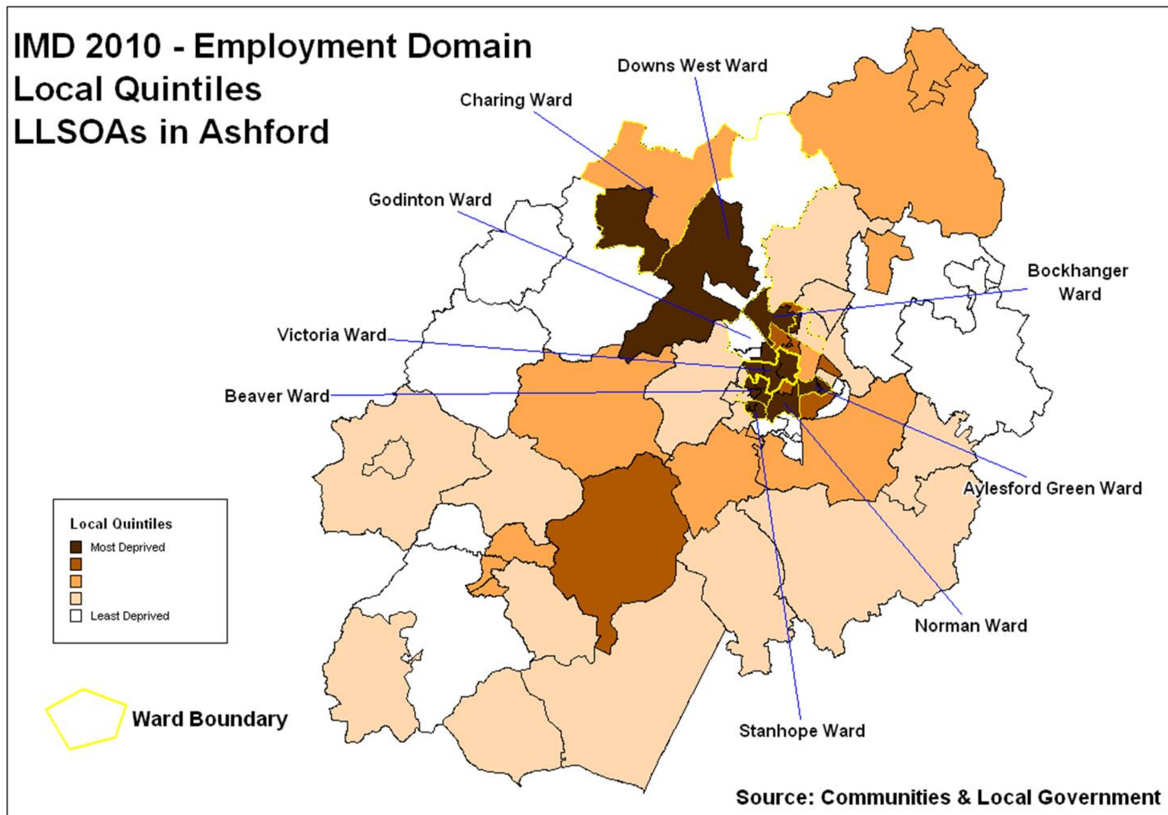
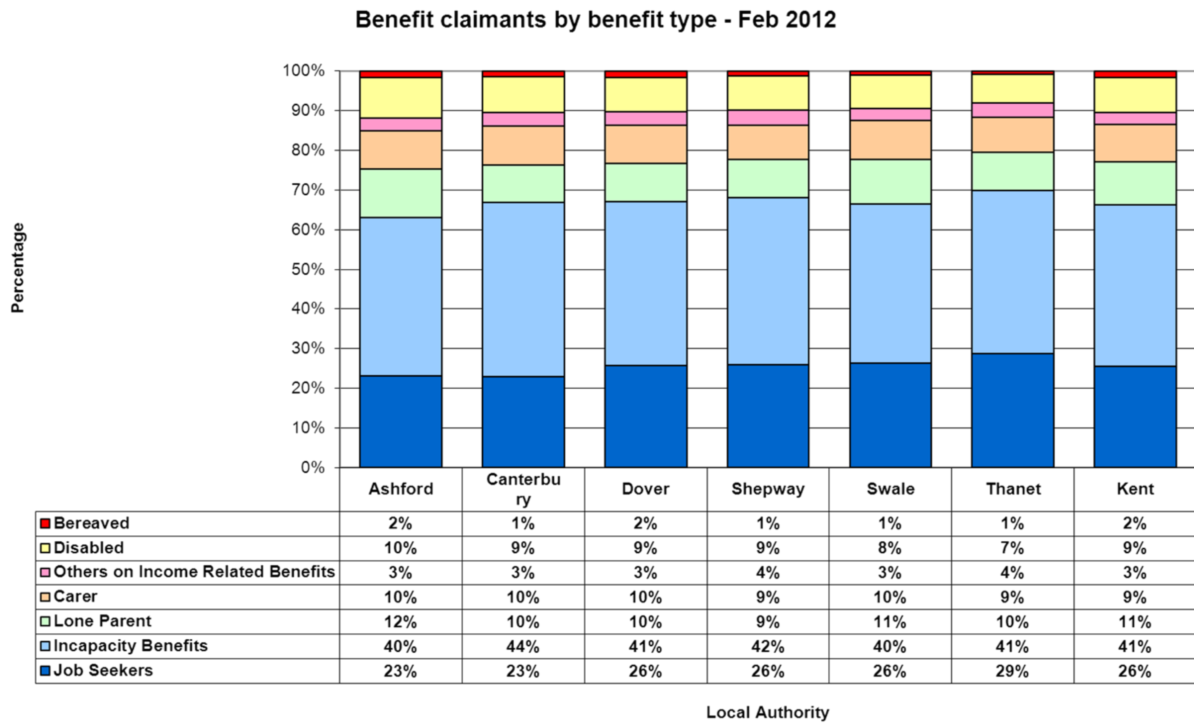


Figure 22: Employment deprivation in Ashford by electoral ward

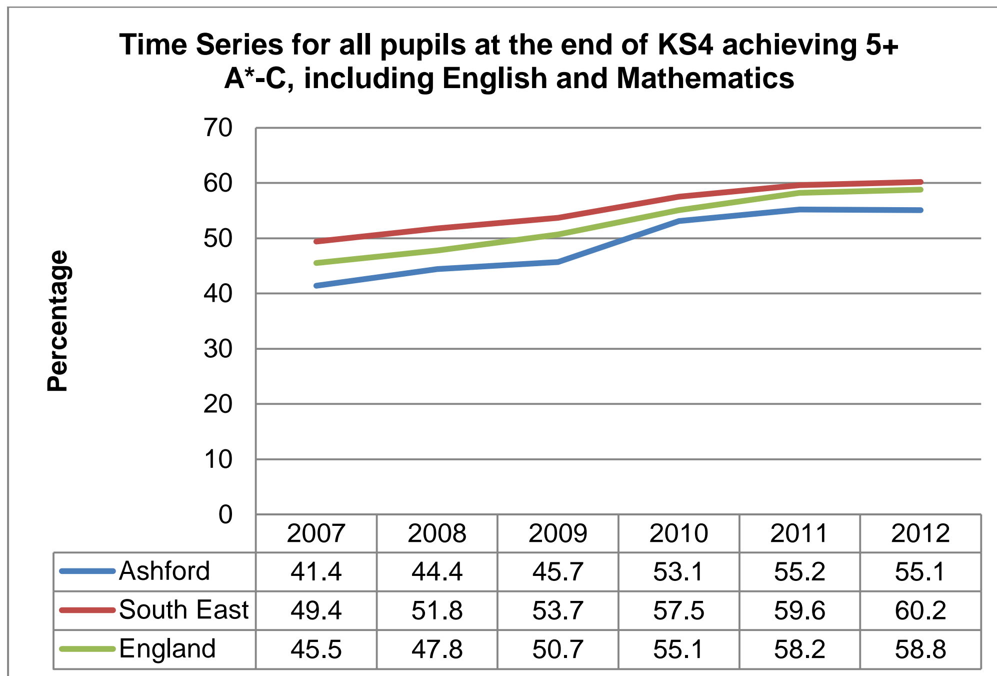
Of those who claim benefits, the majority of people claim for Incapacity Benefits, followed by Job Seekers Allowances. Less people claim for Lone Parent, Carer or Disabled Benefits (Figure 23). This distribution is similar to figures in Kent overall.



	Ashford	Canterbury	Dover	Shepway	Swale	Thanet	Kent
Bereaved	2%	1%	2%	1%	1%	1%	2%
Disabled	10%	9%	9%	9%	8%	7%	9%
Others on Income Related Benefits	3%	3%	3%	4%	3%	4%	3%
Carer	10%	10%	10%	9%	10%	9%	9%
Lone Parent	12%	10%	10%	9%	11%	10%	11%
Incapacity Benefits	40%	44%	41%	42%	40%	41%	41%
Job Seekers	23%	23%	26%	26%	26%	29%	26%

Figure 23: Benefit claims by type in South East Kent Local Authorities and Kent overall

Levels of GCSE attainment in Ashford have improved over time: from 41.4% in 2007 to 55.1% in 2012. The same trend can be seen in the South East and in England overall. Percentages of pupils achieving GCSEs including English and Mathematics were lower in Kent than in the South East or England.



	2007	2008	2009	2010	2011	2012
Ashford	41.4	44.4	45.7	53.1	55.2	55.1
South East	49.4	51.8	53.7	57.5	59.6	60.2
England	45.5	47.8	50.7	55.1	58.2	58.8

Figure 24: GCSE attainment over time, Ashford compared to South East Region and England. Data source: ONS

The areas with highest deprivation on the Education, Skills and Training Domain are shown in Figure 25 and comprise Stanhope Ward, Beaver Ward, Victoria Ward, Downs West Ward, Bockhanger Ward, Bybrook Ward, Aylesford Green Ward and Norman Ward.

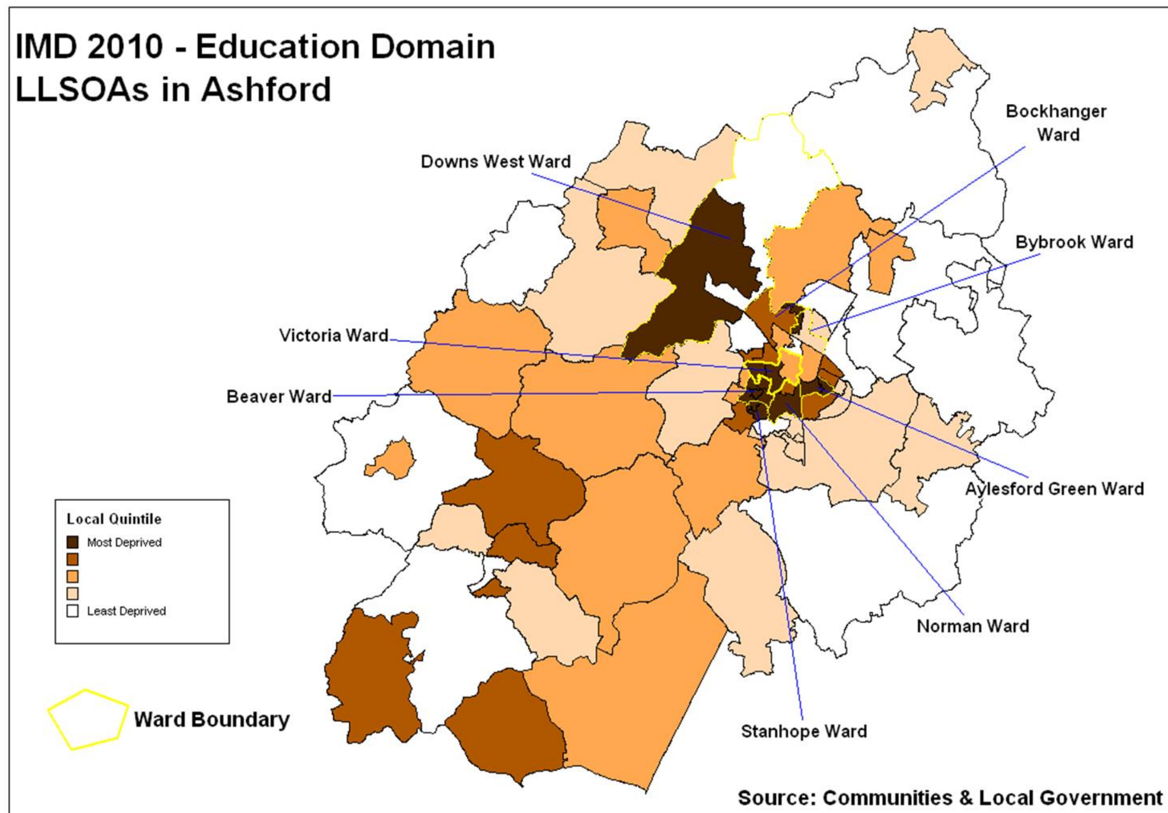


Figure 25: Educational deprivation in Ashford by electoral ward

Education and qualifications are important as achievements in this domain for children and teenagers have direct impact on later employment, income, housing and ultimately health and life expectancy. Lower educational achievements have been strongly linked to deprivation.[2] There are multiple reasons for this. Material deprivation may prevent parents to supply educational resources for their children. Ill health, family stress or low levels of parental education also play a role.

[2] http://skyeward.org.uk/resources/DCSF-Deprivation%20and%20Education.pdf

4.5 BARRIERS TO HOUSING AND SERVICES

This deprivation domain measures physical and financial accessibility of housing and key local services.

Barriers to Housing:

Household overcrowding: proportion of households which are judged to have insufficient space to meet the household's need

Homelessness: the rate of acceptances for housing assistance under the homelessness provisions of housing legislation

Housing affordability: proportion of households under 35 unable to afford owner-occupation

Geographical Barriers to Services:

Road distance to closest GP surgery

Road distance to closest food shop

Road distance to closest primary school

Road distance to closest post office

The deprivation picture for this domain appears reversed to the maps of the previous domains, with areas outside Ashford town experiencing more deprivation (Figure 26). This may be explained with house prices being higher in more rural areas and larger distances to facilities such as GP surgeries, food shops, schools and post offices.

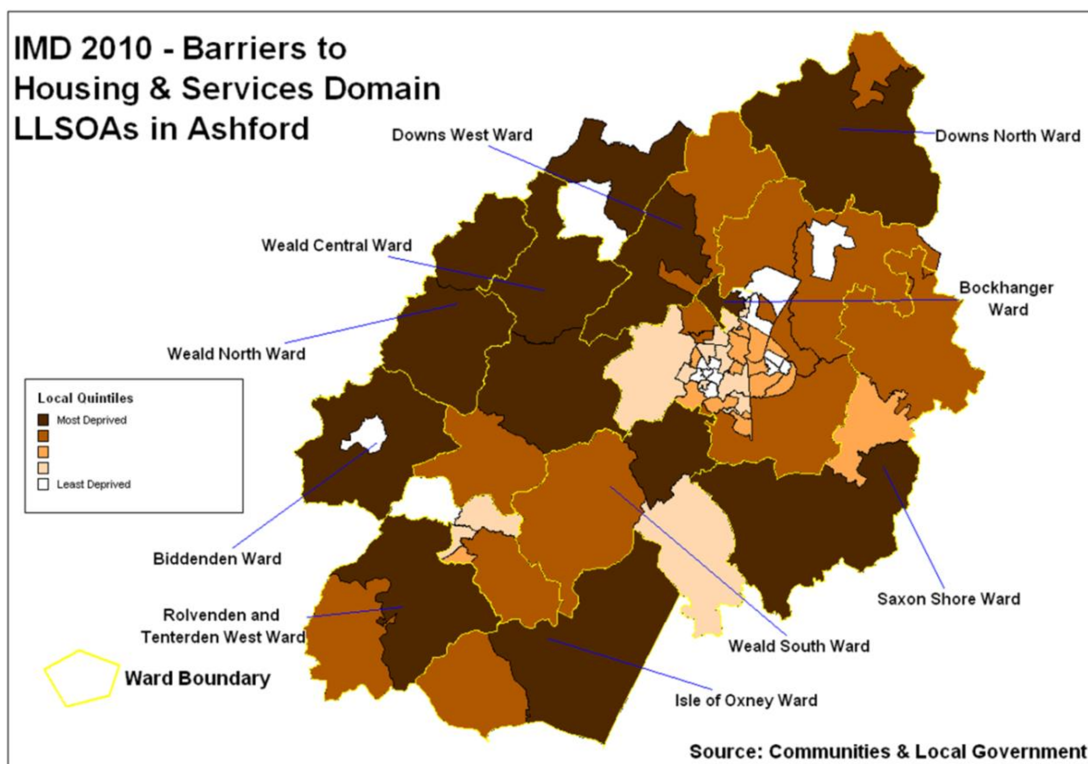
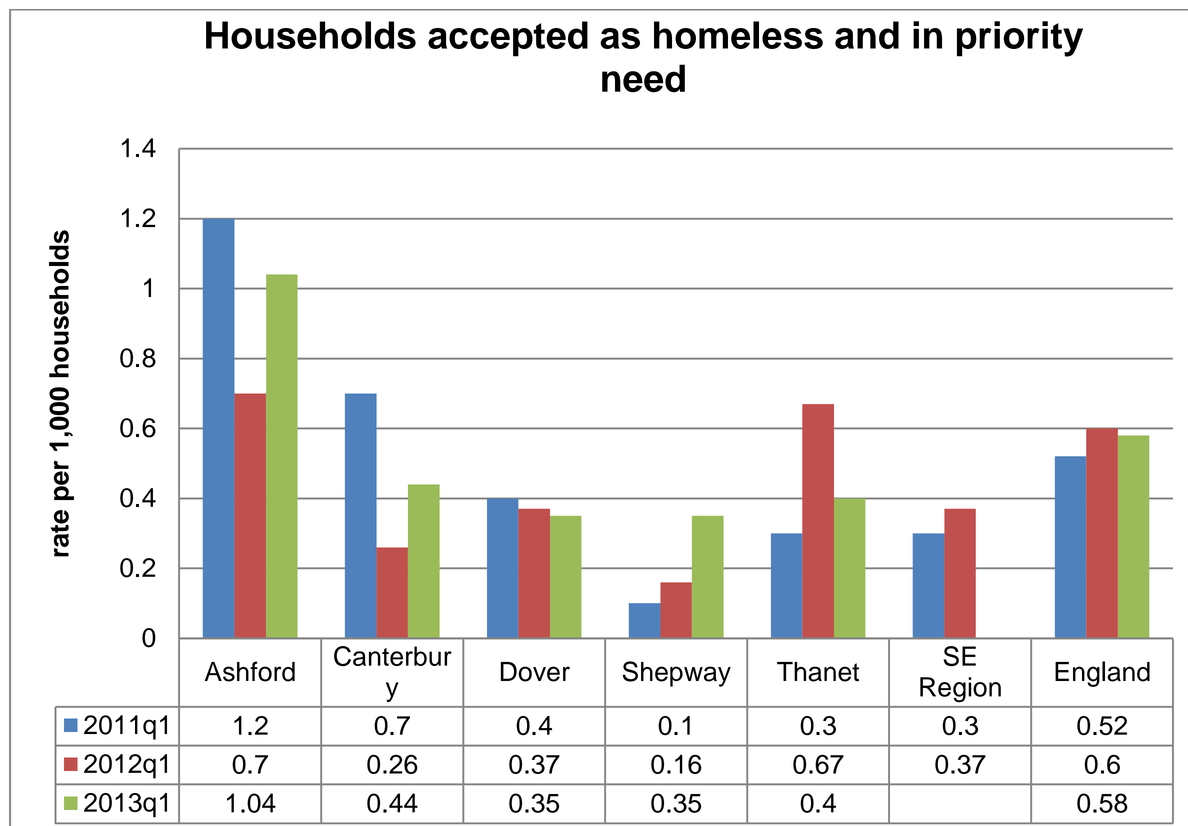


Figure 26: Housing and Services deprivation in Ashford by electoral ward

Homelessness in Ashford is high. Homeless people are not just those “sleeping rough” but include people to whom a homelessness duty has been accepted by a local authority. These are, for example, people who are threatened with the loss of, or are unable to continue with, their current accommodation.

The rates in Ashford are the highest in the Kent area.



	Ashford	Canterbury	Dover	Shepway	Thanet	SE Region	England
2011q1	1.2	0.7	0.4	0.1	0.3	0.3	0.52
2012q1	0.7	0.26	0.37	0.16	0.67	0.37	0.6
2013q1	1.04	0.44	0.35	0.35	0.4		0.58

Figure 27: Homelessness in Ashford compared to the South East and England. Data source: Kent County Council

Health issues associated with homelessness are described in a national audit conducted by “Homeless Link” in 2010[3]:

Over 700 homeless people from across England have contributed to the audit.

Homeless people have high levels of physical health needs. Most commonly reported were chest pain and breathing problems, joint and muscular pain and problems with eye sight, exceeding levels in the general population. 70% of clients had mental health needs and reported feeling often stressed, anxious and depressive. 77% of homeless people smoke which compares to 21% in the general population. Diets were poor and only few consumed fruit and vegetables regularly.

Homeless people used hospital services at a disproportionate rate and in the audit it was demonstrated that 80% of clients had seen a GP within the last 6 months but, additionally, 40% had been to A&E during the same time period.

Apart from the Local Authority duty to advise those assessed as homeless, more support is needed. GP’s are often the first point of contact for health problems but A&E attendance

[3] http://homeless.org.uk/sites/default/files/Health%20Audit%20Findings_National%20evidence.pdf

rates are still high. Any prevention and screening programmes that are rolled out locally or nationally, should reach homeless people and extra effort may be needed to ensure equitable access. Working together with charitable organisations for the homeless may help to reach this population group.

Public Health Interventions and Recommendations:

- In Ashford, only 5% of people live in the most deprived national quintile. The most deprived areas are: Stanhope Ward, Beaver Ward, Victoria Ward, Downs West Ward, Bockhanger Ward, Aylesford Green Ward and Norman Ward. There should be a focus on these areas that access to services is equitable.

- Pupils in Ashford have a lower rate achieving GCSEs including English and Mathematics than pupils in England overall. This may have implications on later achievements in terms of employment, income and ultimately health and wellbeing. A link between deprivation and educational attainment has been demonstrated.
    - A government initiated strategy was the initiation of Sure Start children centres in 1998, established mainly in deprived areas. Although initial evaluations of the programme's effectiveness were disappointing, more recent evaluations were able to demonstrate positive effects including an improvement in the home learning environment[4]. Attendance of activities in children centres should therefore be promoted for families with young children under 5.
    - Health is an important issue for educational attainment. Healthy Schools programmes have been rolled out countrywide and in Ashford, 96% of 54 schools have achieved Healthy School Status. This means that criteria concerning health and physical activity are being achieved. "*A healthy School promotes the health and well-being of its pupils and staff through a well-planned, taught curriculum in a physical and emotional environment that promotes learning and healthy lifestyle choices.*"[5]
    - Government funding is available for schools in areas of highest social disadvantage to offer extended services to children and their parents (extended schools programme[6]). There is some evidence that this programme impacts positively on pupils' attainment and performance[7].

- Homelessness in Ashford is high. Homeless people are vulnerable and have disproportionately more health problems than the general population. Hospital services are used more frequently. The homeless link charity has expressed concerns that health needs of homeless people are currently not met and that commissioners need to ensure that homeless people are recognised. Access is an important issue and they write: "*Many homeless people arrive at health services with acute health problems that could have been addressed earlier on. Preventative services including screening and immunisation must be more routinely accessible. Personalised, flexible services must be accessible at a primary care level: it is unacceptable for these services to exclude patients on the basis of having no permanent address.*"[8]

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[4] http://www.ness.bbk.ac.uk/impact/documents/RB067.pdf
[5] http://www.salisbury.anglican.org/resources-library/schools/schools-every-child-matters/be-healthy
[6] http://www.salisbury.anglican.org/resources-library/schools/schools-every-child-matters/be-healthy
[7] http://www.teachingexpertise.com/articles/evaluation-of-the-full-service-extended-schools-initiative-3080
[8] http://homeless.org.uk/sites/default/files/hl_health-vision-paper_Jan2012.pdf

5 LIFESTYLE

5.1 HEALTHY EATING

"Fruit and vegetables are important components of a healthy diet and their sufficient daily consumption could help prevent major diseases, such as cardiovascular diseases and certain cancers… 1.7 million (2.8%) of deaths worldwide are attributable to low fruit and vegetable consumption...The WHO recommends a minimum of 400g of fruit and vegetables per day."[9]

In Ashford, there is geographical variation in the consumption of fruit and vegetables, with people in more deprived wards eating less than the recommended levels. Less than 15% of people in Beaver Ward, Stanhope Ward and Washford Ward have a high enough consumption of fruit and vegetables that will help protecting from chronic diseases.

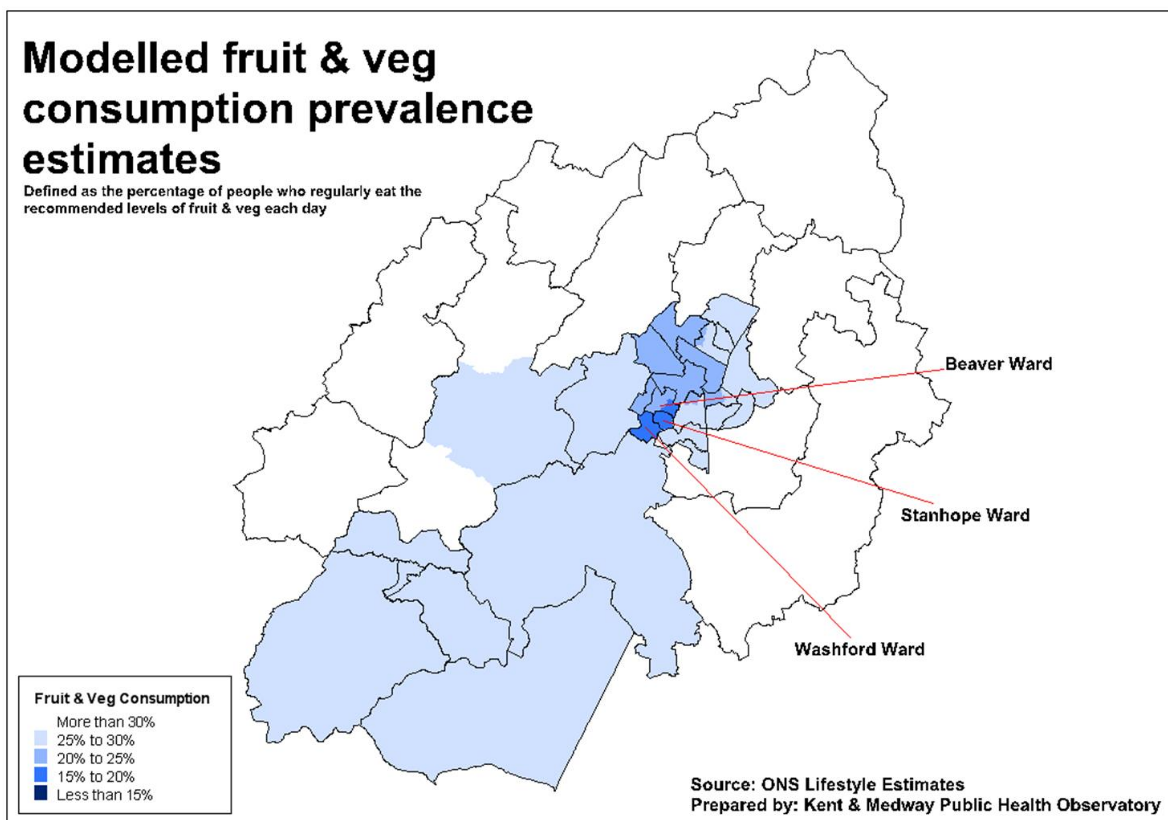


Figure 28: Fruit and Vegetables consumption prevalence in Ashford by electoral ward

[9] http://www.who.int/dietphysicalactivity/fruit/en/

5.2 OBESITY

Obesity is associated with ill health and can lead to cardiovascular disease, diabetes, cancer, osteoarthritis, indigestion, gallstones and obstructive sleep apnoea. Life expectancy is reduced in people who are obese.

Obesity is one of the leading preventable causes of death worldwide.

Obesity prevalence in Ashford is higher in high deprivation areas, with 25-30% of the population being classified as obese. Obesity, however, is not confined to areas of high deprivation. Figure 29 shows that in most other electoral wards the percentage of people being obese is also high, with 20-25%.

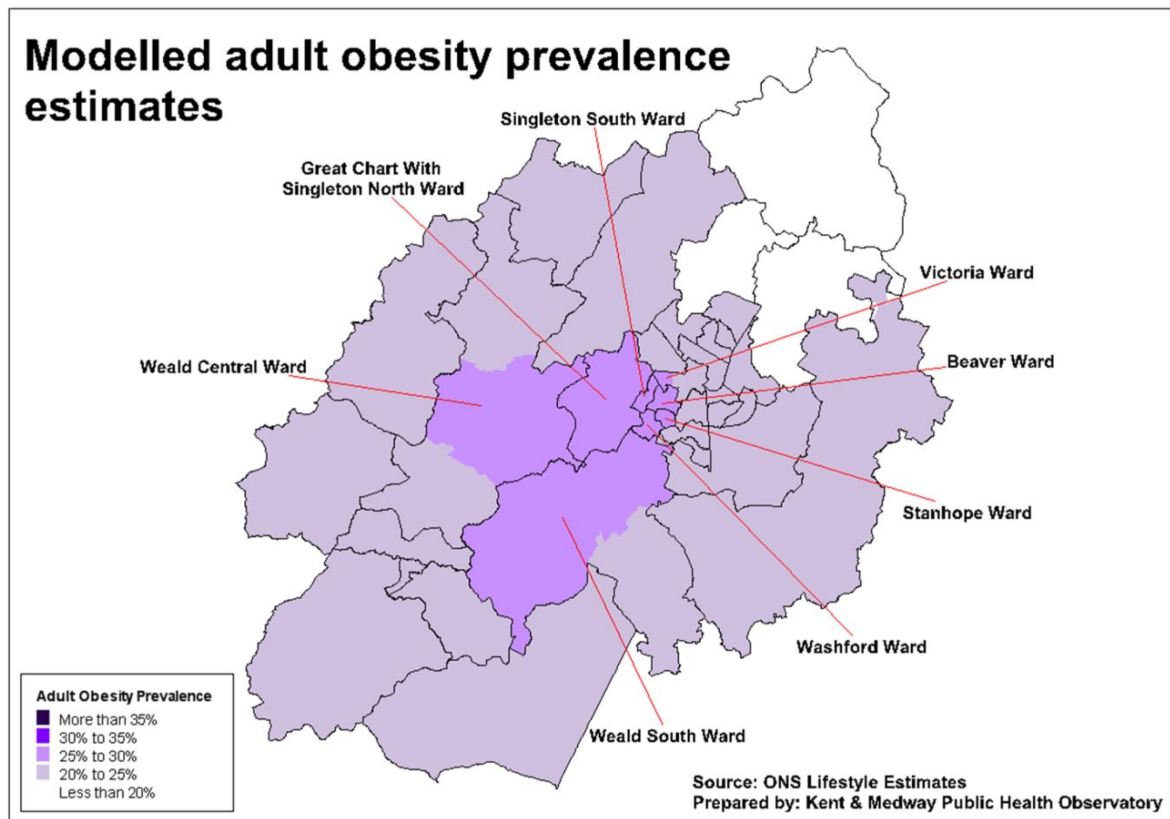


Figure 29: Obesity prevalence in Ashford by electoral ward

The percentage of obese people in the Ashford is with 27% significantly worse than the English average of 24.2% (Figure 30).

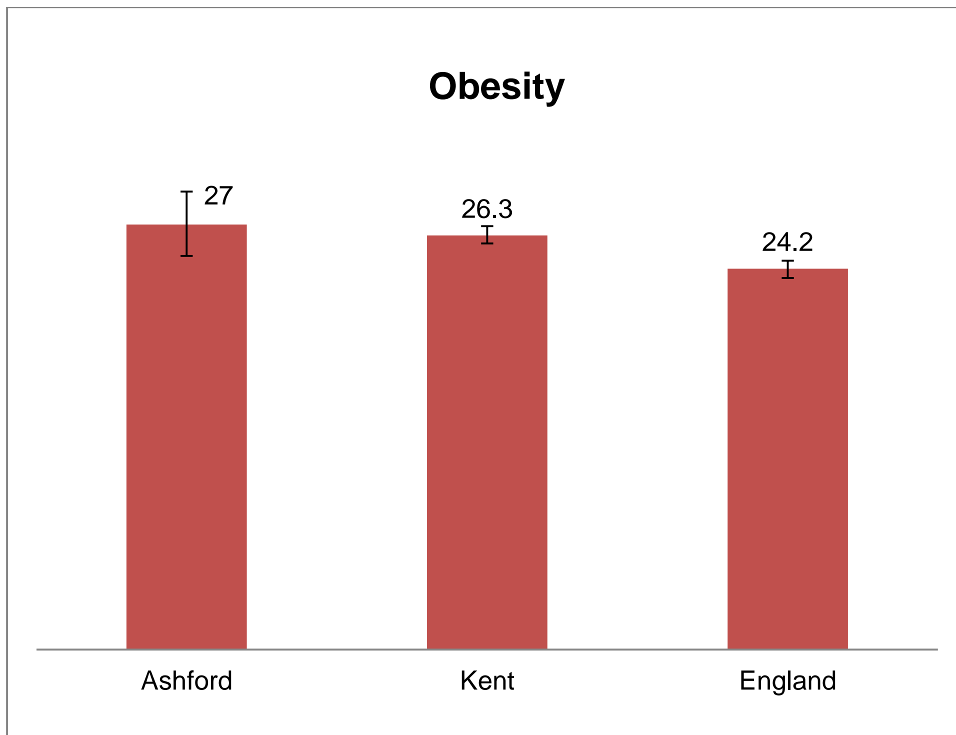


Figure 30: Obesity as a percentage of population aged 16 years and over. Data source: APHO

5.3 EXERCISE

The report "Start Active, Stay Active", published by the Department of Health in 2011[10], highlights the importance of physical activity and gives guidelines for different age groups. Lack of physical exercise shortens life expectancy and is associated with diseases such as coronary heart disease, type 2 diabetes, and breast and colon cancers. Regular exercise protects from disease, improves quality of life and delivers cost savings for health and social care services.

Recommended exercise for adults (19-64 years): 150 minutes of moderate intensity activity in bouts of 10 minutes or more or alternatively 75 minutes of vigorous intensity activity spread across a week.

In Ashford, 54.5% of the population exercise at the recommended level and this is close to the national average of 56%.

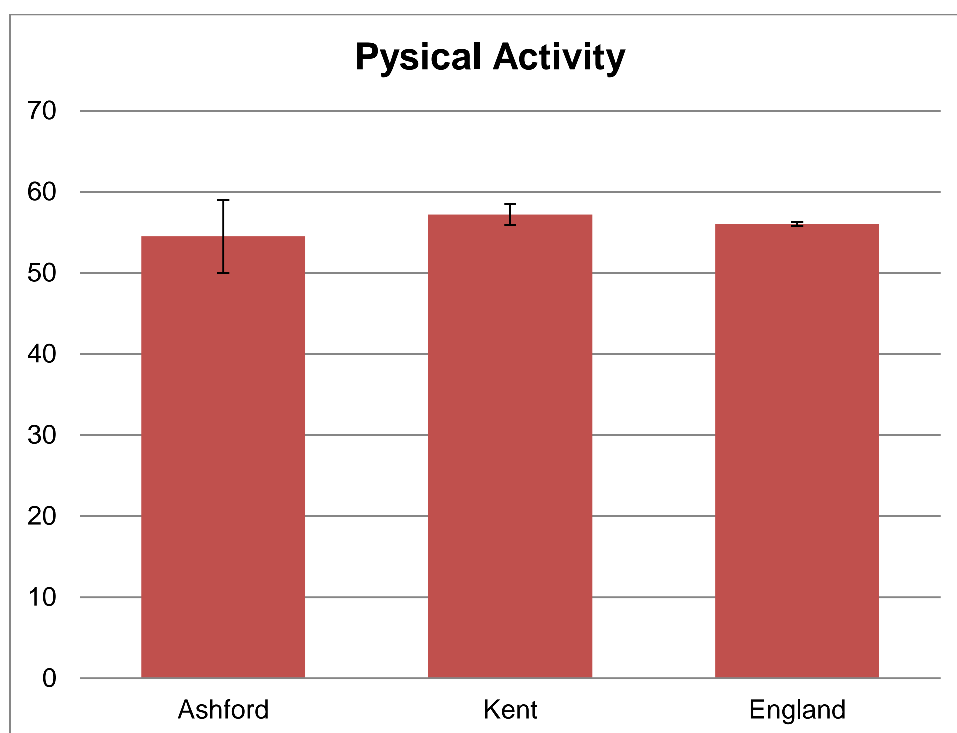


Figure 31: Percentage of population aged 16 and over who participate in recommended levels of physical activity (data Jan 2012 – Jan 2013). Data source: APHO

[10] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf

5.4 SMOKING

Smoking leads to cardiovascular disease, respiratory disease and cancer. It is the single most preventable cause of death worldwide.

It is the "leading cause of health inequalities in the UK today and the principal reason for inequalities in death rates between rich and poor."[11]

In Ashford, almost 35% of people in the most deprived quintile are smokers which compares to less than 20% in the least deprived quintile.

Smoking prevalence is highest in Beaver Ward, Stanhope Ward and Washford Ward with over 35%.

Overall, smoking rates in Ashford are similar to the South East Region and to England rates.

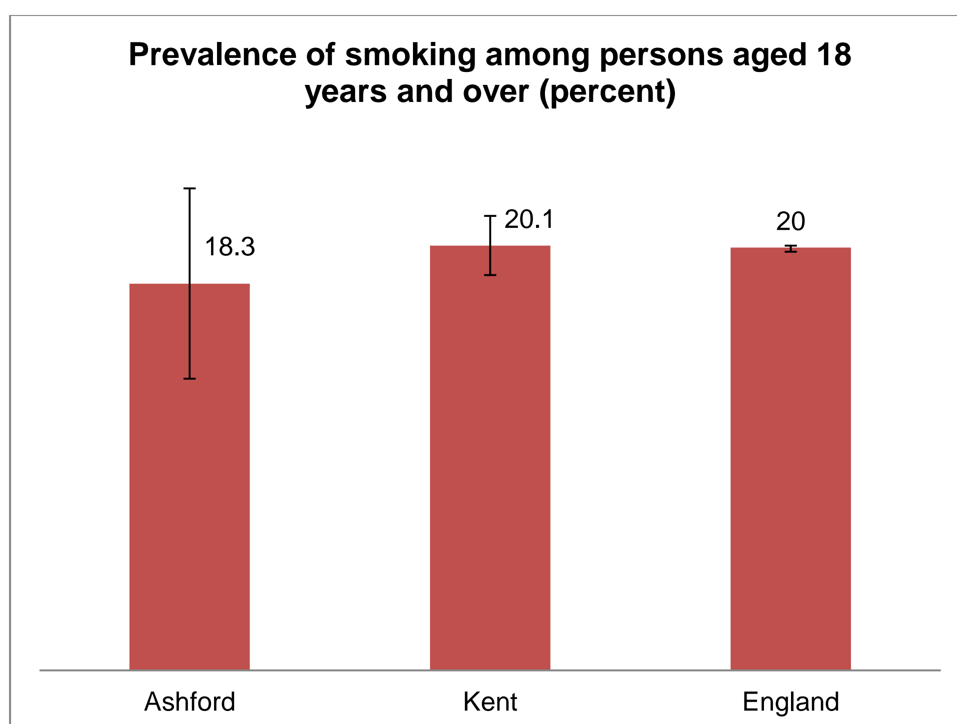


Figure 32: Smoking prevalence. Years 2011-12. Data source: www.tobaccoprofiles.info

5.5 ALCOHOL

Excessive use of alcohol has great impacts on health which range from accidents and injuries to violence, liver disease, pancreatitis and cancers.

Alcohol-attributable mortality in Ashford in 2010 was 17/100,000 for men and 10/100,000 for women.

[11] http://www.nice.org.uk/niceMedia/pdf/Smoking_and_public_health_V6.pdf

Figure 33: Alcohol-attributable mortality. Data source: North West Public Health Observatory.

The figures for women were comparable to the national average. The alcohol-attributable mortality for men was significantly lower than the England average (Figure 34).

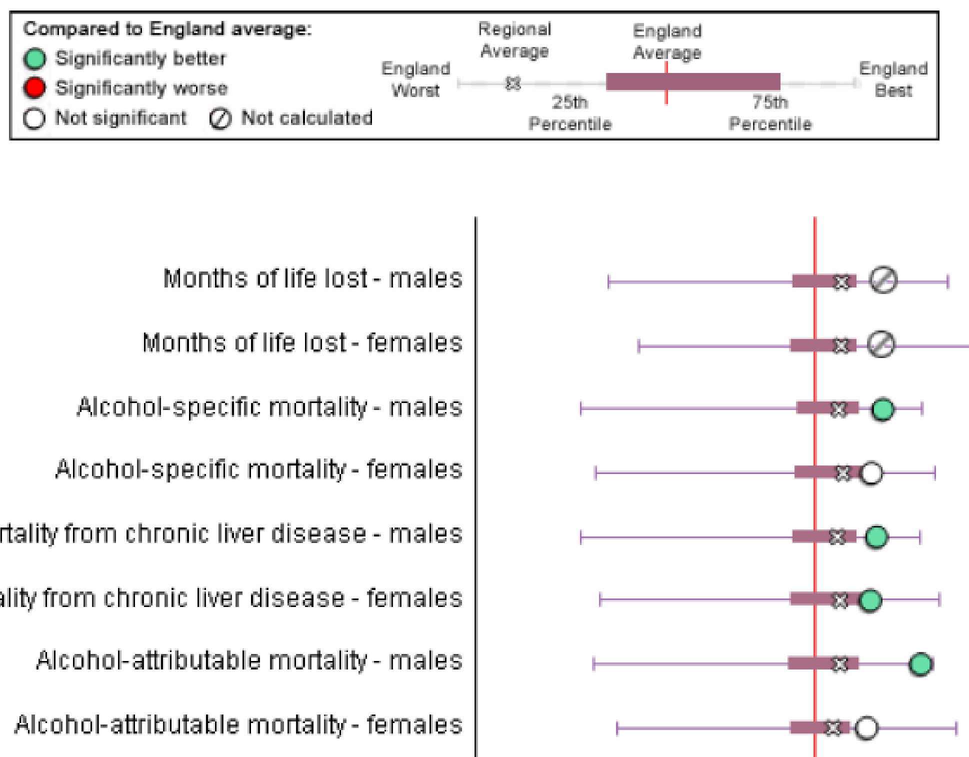


Figure 34: Alcohol consumption and Mortality in comparison to England average. Data source: North West Public Health Observatory.

A rising alcohol-attributable hospital admission rate for men and women, however, is of concern (Figure 35).

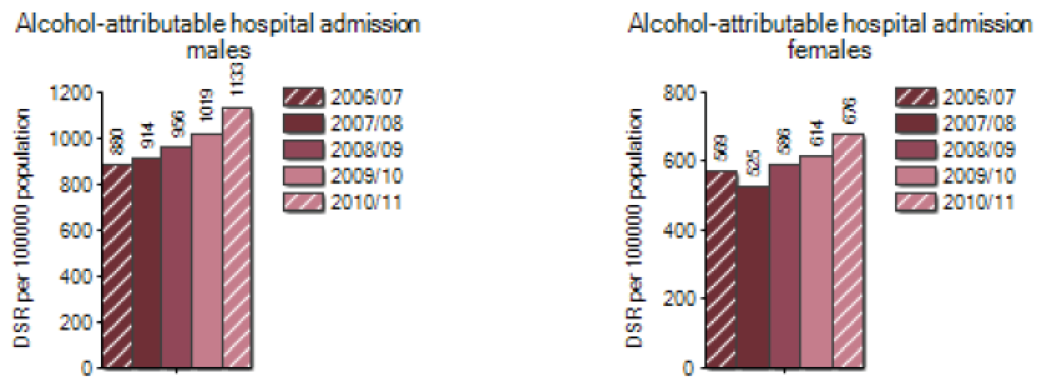


Figure 35: Alcohol-attributable hospital admission rates in Ashford. Source: North West Public Health Observatory

Public Health Interventions and Recommendations:

- People who live in more deprived wards consume less fruit and vegetables. The highest percentage of people with insufficient fruit and vegetable intake live in Beaver Ward, Stanhope Ward and Washford Ward. Public Health Programmes currently commissioned for Ashford give information on healthy nutrition to various population groups. Examples of programmes are: 'Healthy Weight: Fresh Start'; 'Change4Life Clubs'; 'Ready, Steady, GO' and the 'Children and Young people Health and Wellbeing service'. It needs to be monitored that services reach populations in high deprivation areas. NICE published a review on the most effective interventions to promote healthy eating and found the following characteristics important: small programmes, targeted at high risk groups and longer, more intensive interventions with a sound theoretical basis.[12]

- Obesity is a leading preventable cause of death worldwide. The percentage of obese people is with 27% in Ashford significantly higher than the national average of 24.2%. NICE looked at the effectiveness of various interventions for obesity and presented evidence that behavioural interventions are successful at inducing weight loss and that group interventions are superior to individual interventions[13];[14]. Diets were found to be beneficial and better than exercise alone and a combined approach is preferable. Very low Calorie Diets were unable to maintain weight loss over the longer term. A range of health promotion services are available to Ashford residents that encourage healthy eating, physical activity and weight loss. 'Healthy Weight: Fresh Start' is a programme for adults entailing 1:1 appointments with an advisor over three months. Health Trainers are available and give advice and support for taking up healthy life styles, primarily targeting populations from deprived backgrounds. Commissioners may want to consider installing group level interventions in addition, as these could be more (cost) effective according to recommendations from the NICE review.

- Physical activity protects from coronary heart disease and cancer. Levels of physical activity in Ashford are close to the national average with 54.5% of people exercising to recommended levels. Public Health Programmes commissioned for Ashford encouraging physical activity that are not part of a multi–component programme are: 'Health Walks' and 'Exercise Referral Schemes' for people over 16.
  - According to NICE recommendations[15], there is insufficient evidence for the effectiveness of Exercise Referral Schemes and it should only be used as part of a research study.
  - NICE does recommend opportunistic advice to inactive adults identified by primary care practitioners. This should include individually tailored guidance with written information and follow up appointments. The effectiveness should be monitored with a focus on whether it is helping people from disadvantaged groups.

- 35% of people in the most deprived quintile in Ashford are smokers (mainly in Beaver Ward, Stanhope Ward and Washford Ward) which compares to less than 20% in the least deprived quintile. Stop smoking services in Kent have a target of over 9000 quits county wide but this is not currently being met. NICE guidance recommends a "harm-reduction approach to smoking" to reach groups with a high smoking

[12] http://www.nice.org.uk/niceMedia/documents/healthpromo_eatgenpop.pdf
[13] http://www.nice.org.uk/nicemedia/live/11000/56354/56354.pdf
[14] http://www.noo.org.uk/uploads/doc/vid_5189_Adult_weight_management_Final_220210.pdf
[15] http://www.nice.org.uk/nicemedia/pdf/PH002_physical_activity.pdf

prevalence[16]. This consists of cutting down on smoking before setting a quit date, supported by the use of licensed nicotine-containing products. The programme should be commissioned for Kent next year (2014).

- Alcohol-attributable mortality in Ashford is comparable to rates in England for women and significantly better than rates in England for men. These figures are encouraging. Hospital admission rates for alcohol-related reasons are, however, increasing and efforts need to focus on reversing this trend. Drug and alcohol services are available in Ashford; however, these reach individuals that are actively seeking help. The extent of alcohol consumption is often hidden. There are various tools available to carry out screening for alcohol abuse in primary care[17]. This would help detect complications early and offer appropriate help. There is limited evidence but some suggestion that screening and brief advice at primary care level will result in savings to healthcare costs in the long run[18].

[16] http://publications.nice.org.uk/tobacco-harm-reduction-approaches-to-smoking-ph45
[17] http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?ID=12000008520
[18] http://www.nice.org.uk/nicemedia/live/13001/49071/49071.pdf

6 INEQUALITIES BY POPULATION GROUP

6.1 YOUNG PEOPLE

6.1.1 POVERTY

Poverty in childhood is associated with lower life expectancy. Children are more likely to be born with low birth weight, to suffer illness, to have a low education and later in life a low income job. This often leads to a vicious circle with more children born into poverty.

The percentage of children living in poverty in Ashford is lower than in Kent or in England.

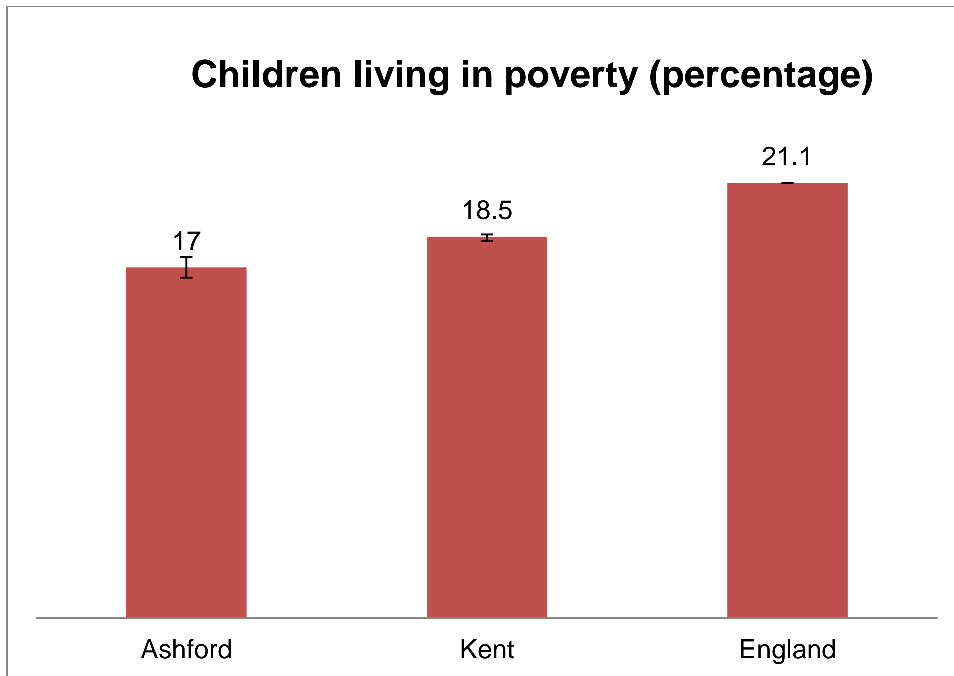


Figure 36: Percentage of children in poverty as compared to the number of child benefit claims, aged 16 and over (2010). Source: APHO data.

There are, however, areas within the Ashford CCG where a high proportion of children live in income deprived families. These areas are found in Stanhope Ward, Tenterden South Ward, Beaver Ward, Charing Ward, Downs West Ward, Bockhanger Ward, Wye Ward, Stour Ward, Victoria Ward, Aylesford Green Ward and Norman Ward (Figure 37).

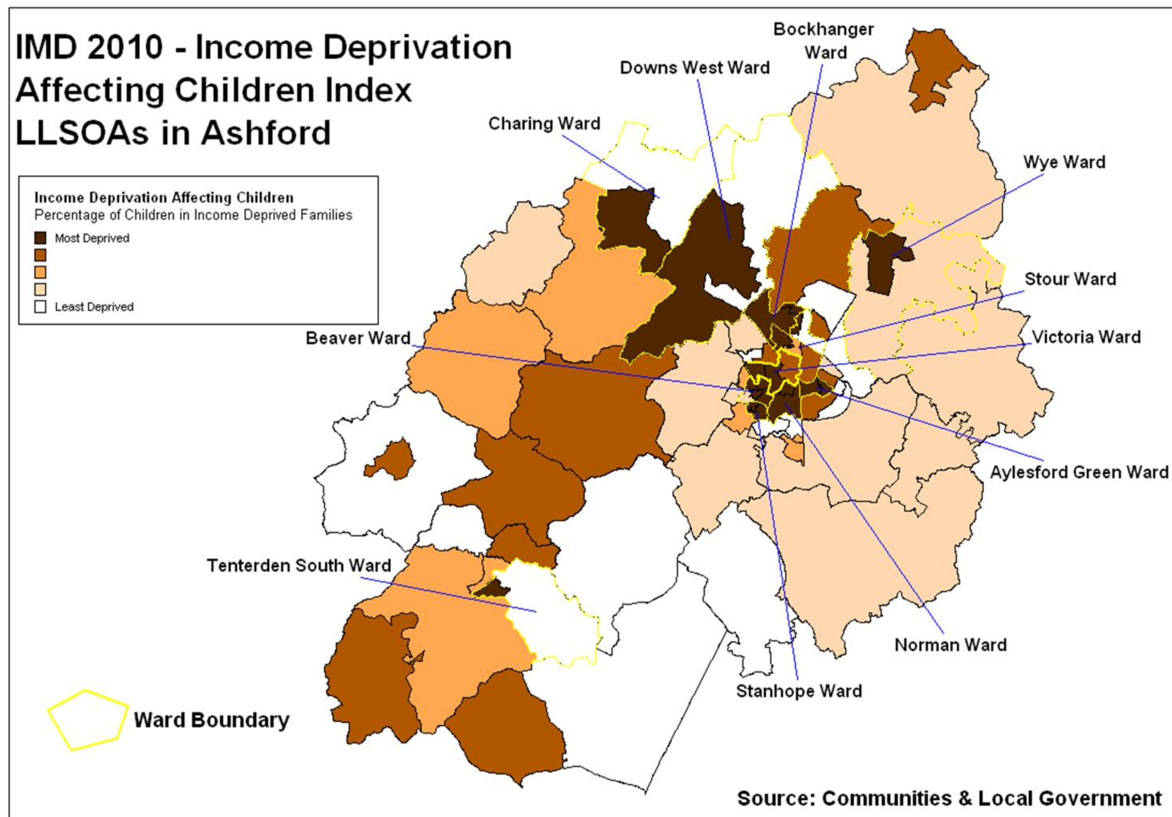


Figure 37: Income deprivation affecting children in Ashford by electoral ward

6.1.2 CHILDHOOD OBESITY

The prevalence of childhood obesity has increased over the last decades and this trend is alarming. Not all obese children go on to be obese in adulthood but the increasing trends of obesity suggest an association with increasingly unhealthy life styles: calorie rich food intake and lack of physical activity. A lifestyle adopted in childhood is likely to continue into adulthood and unhealthy lifestyles may be passed on to future generations.

In Ashford and also nationally, childhood obesity is a significant problem, with almost 20% of children in year 6 being classified as obese, Figure 38.

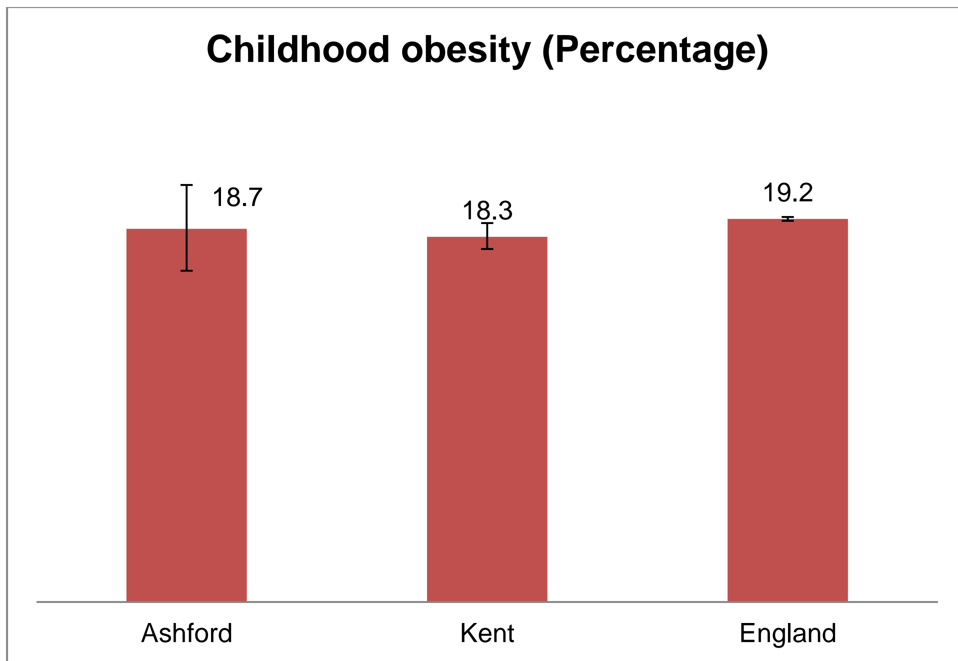


Figure 38: Obesity in children aged 10-11 (year 6). Data source: APHO

In some areas of Ashford, childhood obesity rates are over 25% including Weald South Ward, Isle of Oxney Ward, Weald North, Bockhanger, Kennington and South Willesborough.

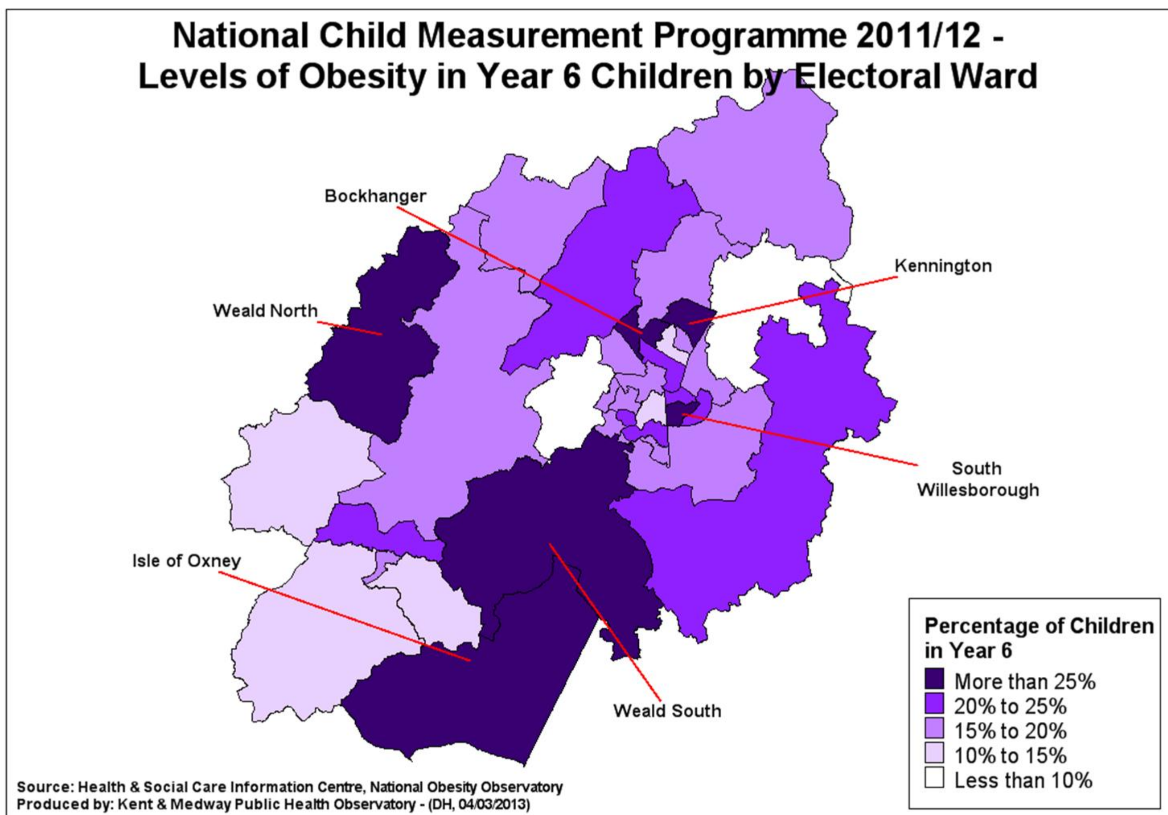


Figure 39: Childhood obesity (Year 6) by electoral ward

6.2 MATERNITY

6.2.1 TEENAGE PREGNANCY

"Teenage pregnancy is an important public health issue: it is common, largely preventable and associated with negative sequelae, both for teenagers who become pregnant and for their children. Compared with babies of older mothers, those born to teenagers are more likely to have lower birth weights, increased infant mortality, an increased risk of hospital admission in early childhood, less supportive home environments, poorer cognitive development and, if female, a higher risk of becoming pregnant themselves as teenagers. Teenaged mothers more often than other teenagers are socially isolated, have mental health problems, and have fewer educational and employment opportunities."[19]

The teenage conception rate in Ashford has decreased over time. With 37.3/1,000 in 2008-10, it is comparable to the England rate but lies significantly above the rate for the South East which is 30.5/1,000 (Figure 40).

Figure 40: Teenage Conceptions – Under 18 Conception Rate, 2008-10. Source: APHO, interactive atlas.

Teenage Conception Rates in Ashford are highest in Stanhope Ward, Victoria Ward, Bockhanger Ward, North Willesborough Ward, Aylesford Green Ward, South Willesborough Ward, Norman Ward and Park Farm North Ward, with 50 – 100/1,000.

[19] Donald B. Langville: Teenage pregnancy: trends, contributing factors and the physician's role. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1867841/

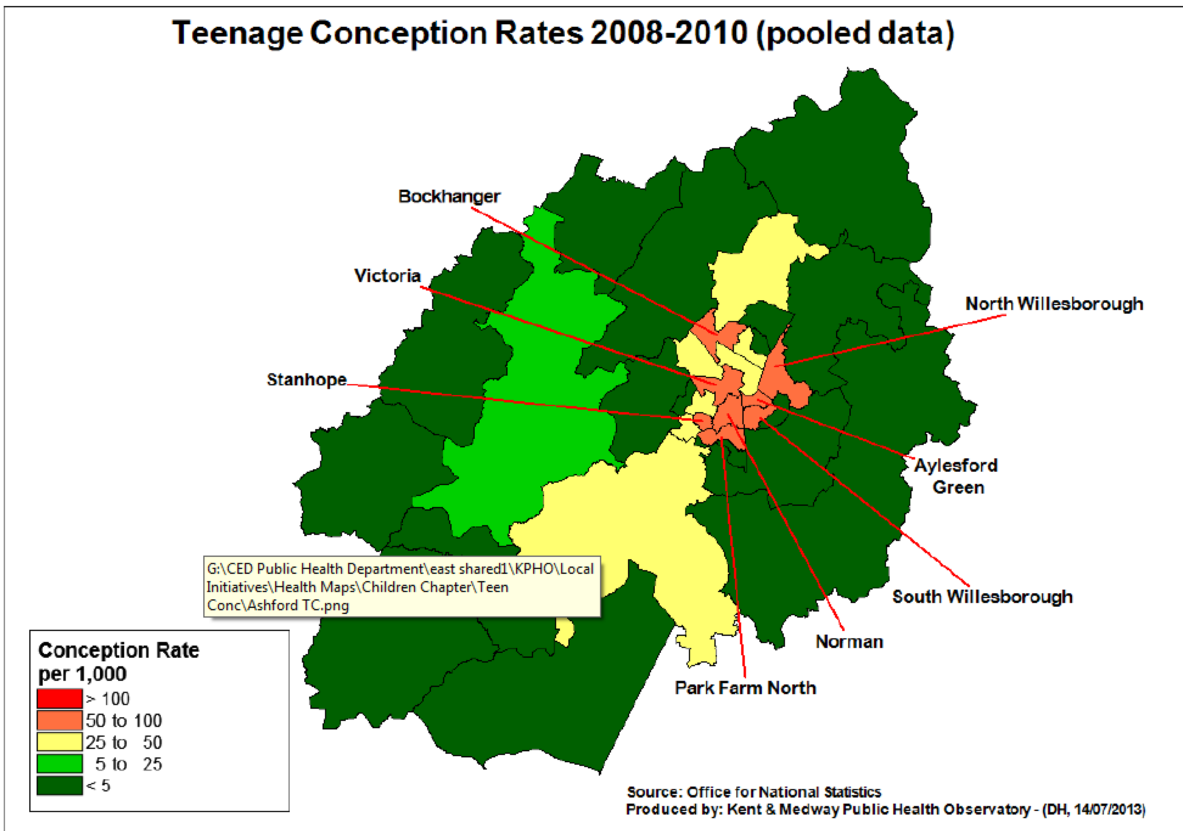


Figure 41: Teenage conception rates in Ashford by electoral ward

6.2.2 SMOKING IN PREGNANCY

"Smoking during pregnancy is associated with many fetal and neo-natal problems such as low birthweight, pre-term delivery, placenta damage, miscarriage and sudden-infant-death syndrome. It can also be the cause of respiratory problems such as chest infections and can aggravate asthma in young children."[20]

In Ashford, smoking in pregnancy is a significant problem with over 18% of mothers smoking at the time of delivery – a rate significantly higher than the rate in the South East or England (Figure 42).

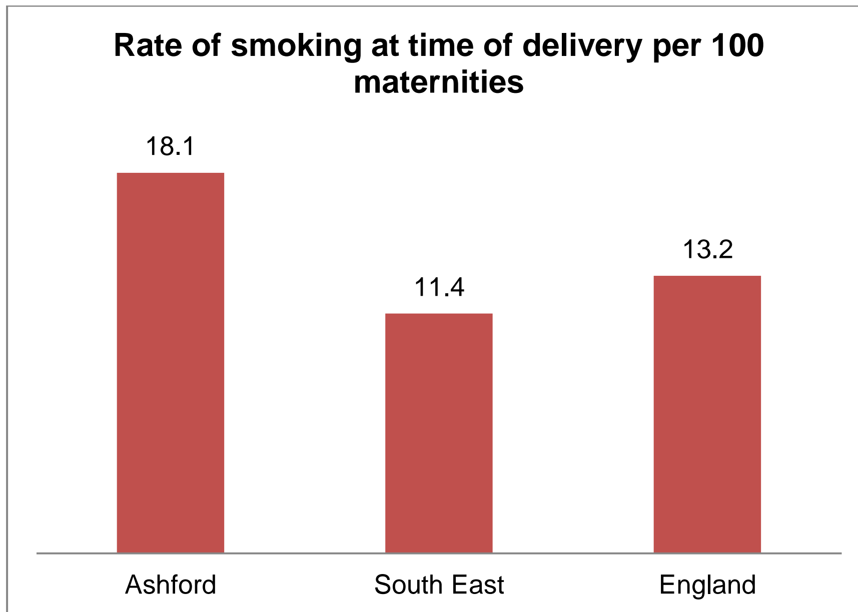


Figure 42: Smoking at time of delivery. Years 2011-12. Data source: www.tobaccoprofiles.info

[20] NICE: http://www.nice.org.uk/nicemedia/documents/smoking_and_pregnancy.pdf

6.2.3 BREAST FEEDING

The WHO recommends exclusive breastfeeding up to 6 months of age[21]:

- Breast milk gives infants all the nutrients they need and antibodies that help protect them
- In the long term, breast fed infants are less likely to become obese and to develop type-2 diabetes
- For mothers, it reduces the risk of breast and ovarian cancer

In Ashford, exclusive breast feeding rates at 6-8 weeks are lower than in Kent and Medway. Lowest breast feeding rates are seen in the most deprived population groups (Figure 43).

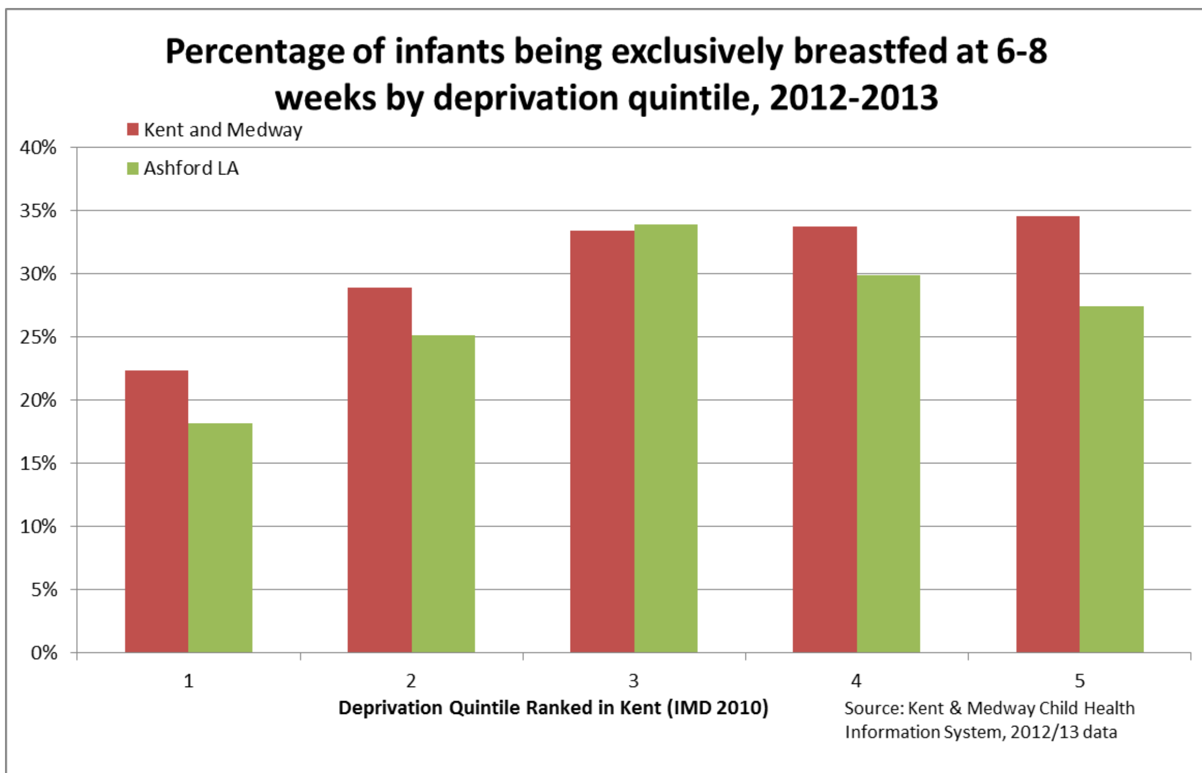


Figure 43: Exclusive breastfeeding at 6-8 weeks by deprivation quintile.

[21] http://www.who.int/features/factfiles/breastfeeding/en/index.html

Breast feeding initiation was with 71.7% significantly lower in Ashford compared to Kent (73.1%) or England (74.8%)

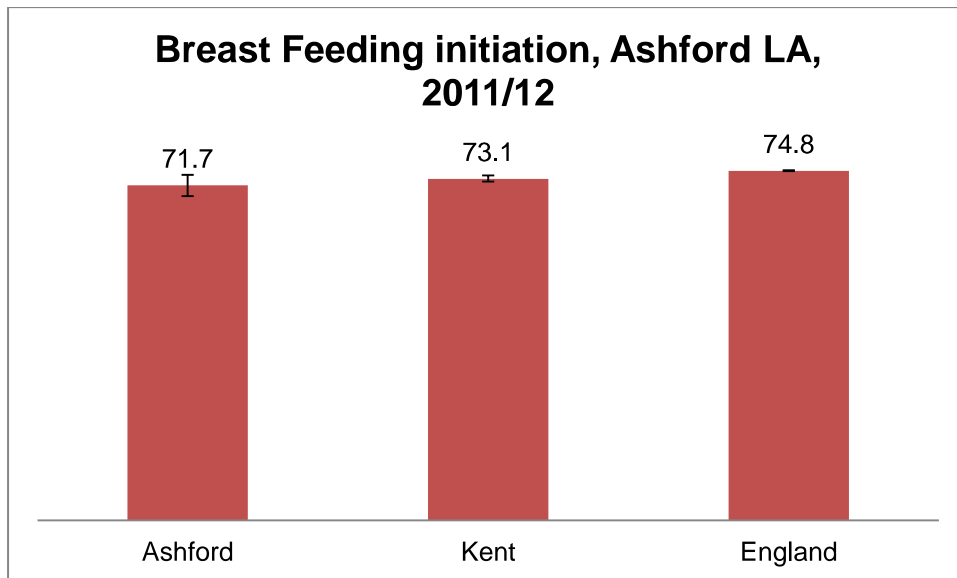


Figure 44: Breast feeding initiation. Data source: APHO.

6.3 OLDER PEOPLE

6.3.1 POVERTY

Many elderly people in the UK live in poverty and this has direct effects on health. As they are already vulnerable due to old age, low living standards with poor housing and insufficient heating during the winter will contribute to ill health. Access to services will be more difficult due to transport and mobility issues.

Income deprivation affecting older people in Ashford is illustrated in Figure 45. A number of electoral wards are considered to be within the most deprived national quintile and this includes almost the whole of central Ashford, with the surrounding wards Downs West, Wye and Biddenden.

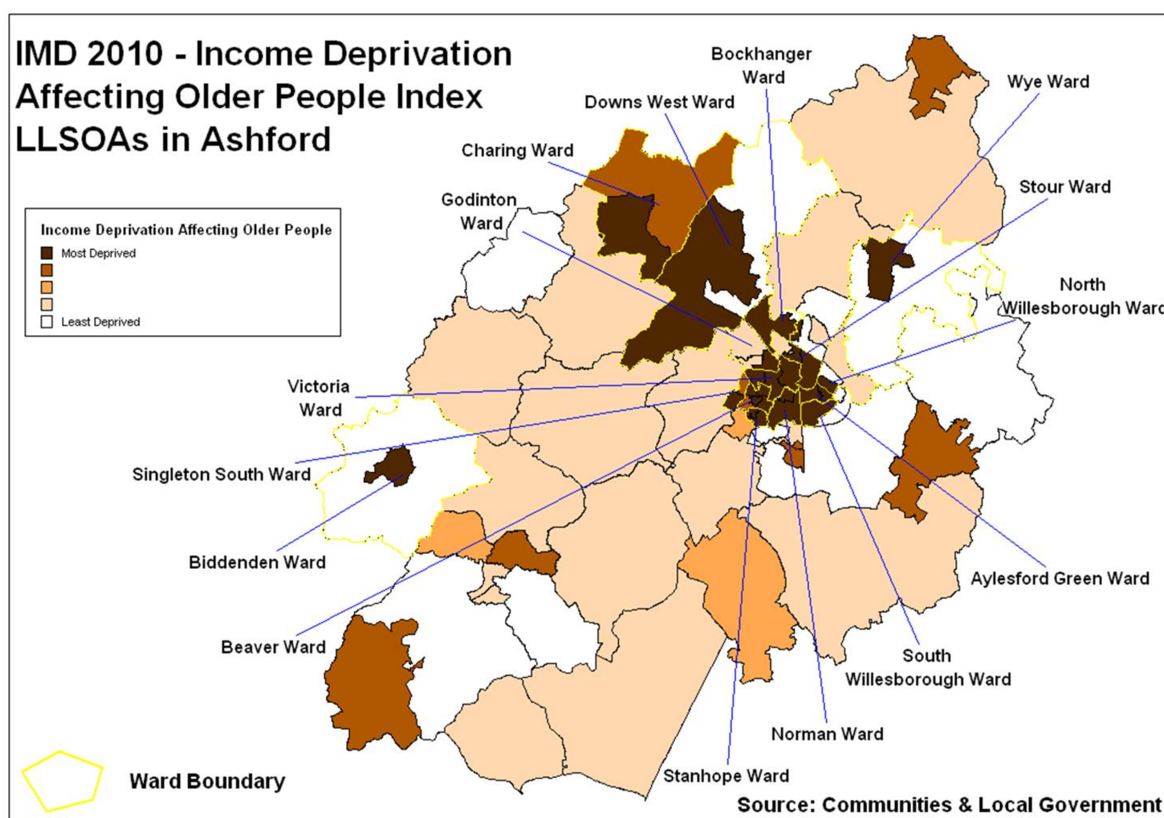


Figure 45: Income deprivation affecting older people in Ashford by electoral ward

6.3.2 FALLS AND FRACTURES

“Every year, over 500,000 older people attend UK Emergency Departments following a fall and 200,000 suffer fractures due to osteoporosis. Falls and fractures in the over-65s account for over 4 million bed days per year in England alone, at an estimated cost of £2 billion. Falls

and fractures often lead to disability and loss of independence, and are the leading cause of accidental death in this age group."[22]

This was part of a press release of the Royal College of Physicians in 2011, after a National Audit of Falls and Bone Health in Older People reported, that "there is unacceptable variation in the quality of NHS services for care and prevention of falls and fractures". Well-designed services can help prevent falls and it is important to respond and provide further services to elderly people when they first present with fractures.

The rate of hip fractures in the over 65 year olds in Ashford corresponds to rates in Kent and England (Figure 46).

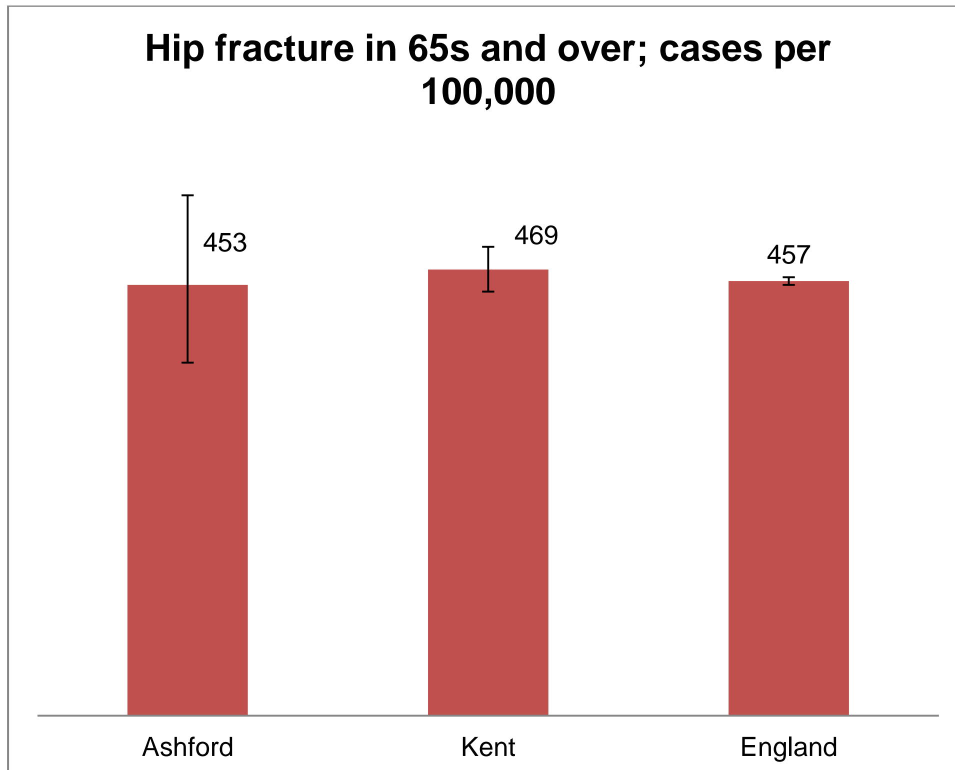


Figure 46: Hip fractures in the elderly. Years 2011-12. Data source: APHO.

Emergency admission rates for hip or shaft of femur fractures are highest for people who live in Singleton South Ward, Godington Ward, South Willesborough Ward and Park Farm South Ward (Figure 47). Services in these areas may need reviewing to see if rates of falls can be reduced in these wards.

[22] http://www.rcplondon.ac.uk/press-releases/nhs-services-falls-and-fractures-older-people-are-inadequate-finds-national-clinical-

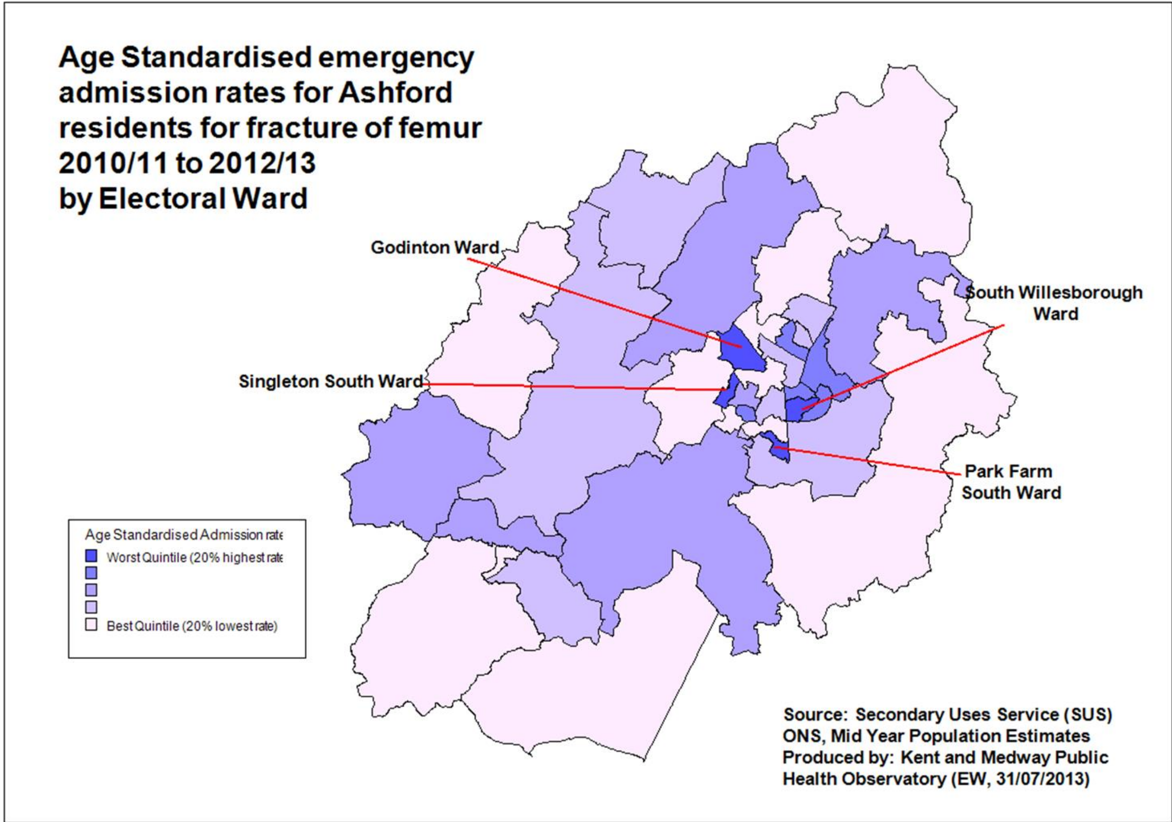


Figure 47: Emergency admission rates for femur fractures in Ashford by electoral ward

Public Health Interventions and Recommendations:

- Childhood obesity is a problem with rates of around 19% in Ashford (similar to rates in England). NICE recommends a combination approach consisting of education and goal setting about healthy eating and physical activity that should be tailored to individual circumstances and preferences. Important is appropriate training of those who deliver interventions including the use of motivational and counselling techniques[23]. There are a variety of Public Health programmes currently being commissioned in the Ashford area that focus on reducing obesity in children: 'Ready, Steady, GO!' – a targeted weight management programme for children aged 7-11; 'Change4 Life Clubs' support families with children aged 7-11 to make healthy lifestyle changes and following the sessions there is the opportunity to become members of the online Healthy Club; 'Healthy Schools' programmes help children of school age to adopt a healthy lifestyle. There should be future evaluations on the effectiveness of these programmes and monitoring of equitable access.

- The teenage pregnancy rate has been decreasing but there are still high rates (50-100/1,000) in some wards within Ashford: Stanhope Ward, Victoria Ward, Bockhanger Ward, North Willesborough Ward, Aylesford Green Ward, South Willesborough Ward, Norman Ward and Park Farm North Ward. The Health Development Agency, Teenage Pregnancy Unit, has published an overview on the research evidence of the effectiveness of interventions to bring down teenage pregnancy rates.
    - There is good evidence that school-based SRE (sex and relationship education) linked to contraceptive services can have an impact on reduction of pregnancy rates.
    - There is good evidence that contraceptive services with the following characteristics are beneficial: long-term provision, clear messages focusing on high risk groups' trained staff, respecting confidentiality of young people, joint-up with other services aimed at preventing pregnancy.
    - There is good evidence that including parents in information and prevention programmes is effective.
    - Youth development programmes have been shown to be most promising. They combine multiple approaches consisting of self-esteem building, voluntary work, educational support, vocational preparation, healthcare, sports, art activities and SRE.
    - Evidence of any impact of condom distribution schemes is not clear.

  In Ashford, school-based SRE is provided within the Healthy Schools programmes. There is also a Kent wide free condom scheme, called C Card with 60 outlets in Ashford and a website www.kentsexualhealth.nhs.uk with further information and a telephone helpline. The initiative HOUSE opened in Ashford in 2011 and offers a place for 13-19 year olds to "hang out". They are offered a range of activities and also advice on sexual health, drugs, relationships etc. These schemes are important for the aim of reducing the teenage pregnancy rates further and it needs to be ensured that the right target groups are reached.

[23] http://www.nice.org.uk/nicemedia/live/11000/30365/30365.pdf

- Smoking during pregnancy is a significant problem in Ashford. NICE has published guidance on quitting smoking in pregnancy and following childbirth.
    - Interventions shown to be effective are: cognitive behaviour therapy; motivational interviewing; structured self-help and support from NHS Stop Smoking Services.
    - Primary Care practitioners need to be aware that some pregnant women find it difficult to admit to smoking because of the pressure resulting. NICE therefore recommends a CO test done by a midwife at the booking appointment. Limitations of this test and interpretation of results are recognised.
    - Every pregnant woman who smokes or has recently stopped (within previous 2 weeks) should be given information on the risks and be offered a referral to the Stop Smoking service.
    - Commissioners should ensure that all staff (midwifes, smoking advisors etc.) have appropriate training and know how to ask questions in a way that women speak openly, know how to use a CO monitor and know which services to offer to this specific group.

- Breast feeding initiation rates are lower in Ashford than in Kent or England. It is important to encourage breast feeding as this has positive health effects on mother and baby. Some evidence on the effectiveness of different interventions to increase breastfeeding was published by the Health Development Agency[24]:
    - Education on breastfeeding is beneficial: not so much the distribution of leaflets alone but educational group sessions can be effective among low income groups and 1:1 educational programmes were effective for women who planned to bottle-feed.
    - Promotions delivered over both the ante- and postnatal period had a positive effect.
    - Within the health service, there is some limited evidence that training of staff, employment of a breastfeeding consultant and more home-like rooms in the hospital were effective in the USA among low income women.
    - Social support at home by midwifes for socially disadvantaged women has not shown any benefits over usual care
    - Peer support programmes were not effective for women who decided to bottle-feed.
    - Media campaigns help improving attitudes towards breastfeeding

- Rates of hip fractures in the elderly in Ashford are comparable to England but are high in the wards Singleton South, Godington, South Willesborough and Park Farm South. NICE recommends the following[25]:
    - Older people aged over 65 in contact with healthcare professionals should routinely be asked whether they have fallen in the past year.
    - Any people at risk should be offered a multifactorial falls risk assessment = referral to a specialist falls service.
    - Any people at risk should be considered for multifactorial interventions, which could include strength and balance training, home hazard assessment, vision assessment, medication review.

  The Kent Community Health Trust is providing a Falls Prevention Service for East Kent. Access and uptake of these services, in particular for elderly people living in the above wards, should be reviewed and referrals made appropriately.

[24] http://www.nice.org.uk/nicemedia/documents/breastfeeding_summary.pdf
[25] http://www.nice.org.uk/nicemedia/live/14181/64088/64088.pdf

7.1 EMERGENCY A&E ADMISSIONS

The percentage of emergency admissions in Ashford during 2011-12 was with 37.7% significantly lower than rates in Kent (42.2%) and England (40.6%), Figure 48.

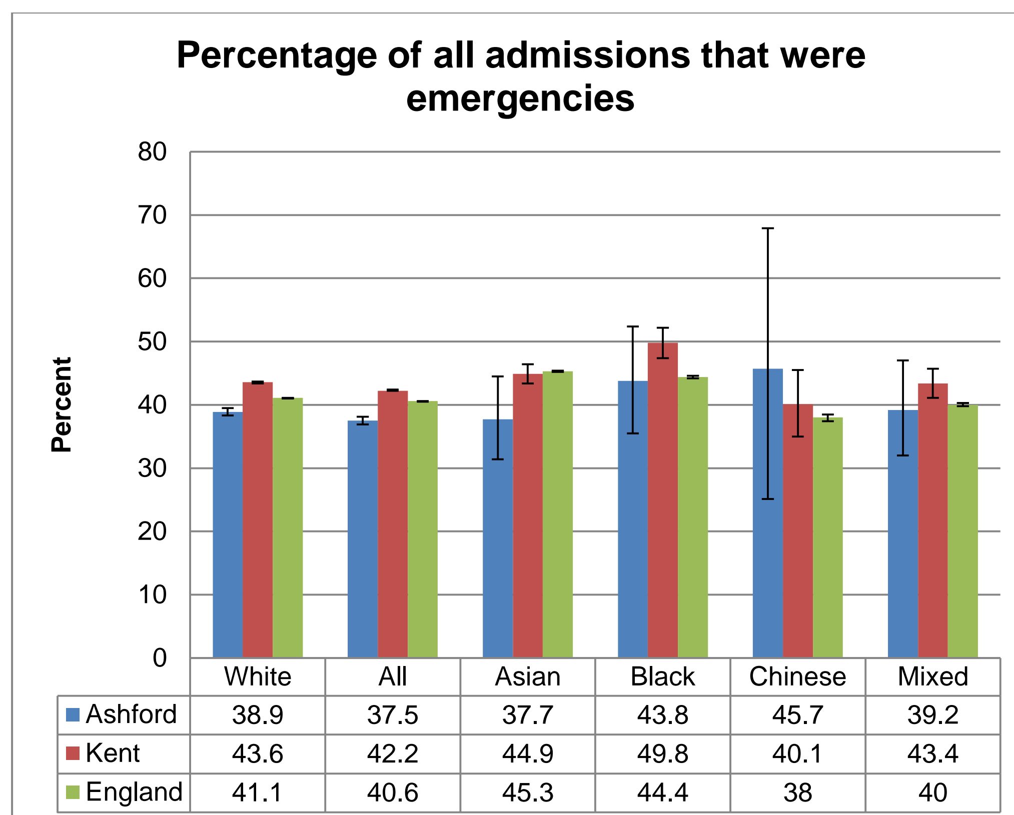


Figure 48: Percentage of emergency hospital admissions. Years 2011-12. Data source: APHO

Ethnic minorities, with Black people in particular, had a higher rate of emergency admissions.

7.2 VACCINATION UPTAKE

Vaccination saves lives. The WHO estimates that vaccination prevents about 2.5 million deaths worldwide each year. Primarily, the aim of vaccination is to protect the individual that receives the vaccine but at the same time, vaccinated people are less likely to be a source of infection to others. The more people are vaccinated in a population, the less likely are unvaccinated people to be infected. It is thought that at about 95% immunity in a population the risk of infection for non-immune people is eliminated and this is called herd immunity.

Therefore, practices should aim at vaccination coverage of about 95% in their population, according to WHO targets.

The tables below show vaccine uptake by practice and it shows that most practices reach a target of 95% and above for most childhood vaccinations.

Ashford LA: 12/13 GP Practice Level Vaccinations 01/04/12-31/03/13
Source: Child Health Computer

Key	WHO Targets
	95% and above
	90.0%-94.99%
	<90%

G code	Practice Name	CCG	LA	Up to 1st birthday			Up to 2nd birthday primaries				Up to 2nd birthday boosters	
				DTap/IPV/ Hib	Men C	Pneu	DTap/IPV/ Hib	MMR 1	Men C	Pneu	Hib/MenC	Pneu
PCT				95.6	95.2	95.4	97.6	94.7	96.7	97.7	94.7	95.6
LA				97.1	96.4	96.9	98.5	95.6	97.7	98.7	96.4	97.1
G82049	Hollington Surgery	Ashford CCG	Ashford	97.8	97.8	97.8	100.0	97.9	100.0	100.0	100.0	100.0
G82050	Sydenham House	Ashford CCG	Ashford	98.4	97.8	98.4	98.9	94.4	98.3	99.4	96.1	97.8
G82053	Woodchurch Surgery	Ashford CCG	Ashford	83.3	83.3	83.3	96.2	96.2	96.2	96.2	96.2	96.2
G82080	Willesborough Health Centre	Ashford CCG	Ashford	97.6	97.6	97.6	100.0	98.2	98.8	99.4	98.2	98.8
G82087	New Hayesbank Surgery	Ashford CCG	Ashford	98.4	97.9	98.4	99.4	98.3	98.3	98.9	98.3	98.9
G82094	Charing Medical Partnership	Ashford CCG	Ashford	100.0	96.0	97.3	95.7	92.8	94.2	95.7	95.7	95.7
G82114	Ivy Court Surgery	Ashford CCG	Ashford	98.3	97.4	98.3	97.0	92.5	97.0	97.7	94.7	95.5
G82142	Wye Surgery	Ashford CCG	Ashford	96.8	96.8	96.8	96.6	93.1	95.4	97.7	93.1	95.4
G82186	Hamstreet Surgery	Ashford CCG	Ashford	98.6	97.3	97.3	100.0	97.0	100.0	100.0	97.0	97.0
G82658	Sellindge Surgery	Ashford CCG	Ashford	100.0	100.0	100.0	100.0	98.0	100.0	100.0	100.0	100.0
G82688	Singleton Surgery	Ashford CCG	Ashford	96.6	93.2	94.9	100.0	98.0	98.0	100.0	98.0	100.0
G82712	Singleton Medical Centre	Ashford CCG	Ashford	95.1	95.1	95.1	98.0	98.0	95.9	98.0	98.0	98.0
G82730	Kingsnorth Medical Practice	Ashford CCG	Ashford	96.4	96.4	97.8	100.0	94.2	99.3	100.0	97.1	96.4
G82735	St Stephens Health Centre	Ashford CCG	Ashford	93.8	93.2	93.8	97.5	97.5	96.9	98.1	95.7	97.5
G82748	Musgrove Park Medical Centre	Ashford CCG	Ashford	96.2	96.2	96.2	95.6	89.0	94.5	96.7	91.2	90.1

Figure 49: Vaccination coverage by GP practice up to second birthday

Ashford LA: 12/13 GP Practice Level Vaccinations 01/04/12-31/03/13
Source: Child Health Computer

Key	WHO Targets
	95% and above
	90.0%-94.99%
	<90%

G code	Practice Name	CCG	LA	Up to 5th birthday primaries				Up to 5th birthday boosters				Up to 14th birthday
				Dtap/IPV/ Hib	MMR 1	Men C	Pneu	DTPP	MMR 2	Hib/Men C	Pneu	Rubella
PCT				97.4	95.8	94.8	95.9	93.9	92.0	94.5	92.5	83.7
LA				97.9	96.8	95.6	96.7	94.9	93.5	95.8	94.9	81.0
G82049	Hollington Surgery	Ashford CCG	Ashford	100.0	97.4	97.4	100.0	100.0	97.4	97.4	100.0	75.0
G82050	Sydenham House	Ashford CCG	Ashford	97.4	96.9	96.9	97.4	95.4	93.4	96.4	97.4	90.4
G82053	Woodchurch Surgery	Ashford CCG	Ashford	100.0	100.0	97.2	100.0	100.0	100.0	97.2	100.0	84.2
G82080	Willesborough Health Centre	Ashford CCG	Ashford	98.9	97.7	93.1	94.9	94.3	94.3	95.4	92.6	81.3
G82087	New Hayesbank Surgery	Ashford CCG	Ashford	97.9	97.9	94.1	96.3	95.7	95.7	95.7	95.7	84.6
G82094	Charing Medical Partnership	Ashford CCG	Ashford	98.9	91.3	98.9	97.8	93.5	89.1	95.7	92.4	83.3
G82114	Ivy Court Surgery	Ashford CCG	Ashford	96.7	95.9	95.1	95.9	90.2	87.8	94.3	95.1	80.9
G82142	Wye Surgery	Ashford CCG	Ashford	98.9	97.9	96.8	96.8	96.8	94.7	97.9	94.7	82.5
G82186	Hamstreet Surgery	Ashford CCG	Ashford	98.8	96.5	97.7	98.8	96.5	91.9	97.7	94.2	86.7
G82658	Sellindge Surgery	Ashford CCG	Ashford	96.1	94.1	88.2	92.2	90.2	90.2	90.2	90.2	95.5
G82688	Singleton Surgery	Ashford CCG	Ashford	96.1	96.1	96.1	96.1	94.1	94.1	96.1	94.1	84.2
G82712	Singleton Medical Centre	Ashford CCG	Ashford	96.5	96.5	96.5	96.5	96.5	96.5	96.5	94.7	76.2
G82730	Kingsnorth Medical Practice	Ashford CCG	Ashford	99.4	100.0	98.2	99.4	98.2	97.0	97.6	98.8	79.3
G82735	St Stephens Health Centre	Ashford CCG	Ashford	97.2	97.2	95.9	95.9	95.2	95.2	94.5	93.8	66.7
G82748	Musgrove Park Medical Centre	Ashford CCG	Ashford	95.3	93.0	91.9	94.2	88.4	86.0	93.0	88.4	55.6

Figure 50: Vaccination coverage by GP practice, up to 14th birthday

7.3 SCREENING UPTAKE

Cancer screening uptake is essential to increase the proportion of cancers diagnosed at an early stage. There is variation in uptake for different population sub-groups and it has been observed that uptake is lower in deprived communities[26].

[26] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2790712/pdf/6605391a.pdf

The national target for breast screening uptake is >70%. Most practices within Ashford CCG have been achieving this target, Table 1

Breast Screening, percentage positive uptake, by practice, three years ending 31 March 2012

GP Code	GP Name	Eligible Practice Population	Number screened	% Uptake
G82735	South Ashford Medics	483	292	60.46%
G82748	Musgrove Park	415	257	61.93%
G82688	Dr Setty M V S & Partner	265	195	73.58%
G82049	Hollington Surgery	319	238	74.61%
G82186	Hamstreet Surgery	878	661	75.28%
G82712	Dr Thomas A	245	187	76.33%
G82142	Wye Surgery	969	744	76.78%
G82050	Sydenham House Medical Centre	1298	1011	77.89%
G82730	Dr Kelly J C & Partners	842	657	78.03%
G82087	New Hayesbank Surgery	1463	1147	78.40%
G82094	The Charing Surgery	1059	835	78.85%
G82080	The Willesborough Medical Ctr	1283	1012	78.88%
G82114	Ivy Court Surgery	1977	1638	82.85%
G82053	Front Road Surgery	463	386	83.37%
Ashford LA		11959	9260	77.43%
Kent and Medway		186431	145953	78.29%

Source: PCIS

Table 1: Breast Cancer Screening uptake

Figure 51 illustrates breast screening uptake by deprivation quintile of the area where practices are located. The figure shows that uptake is worst in patient populations that are registered with a GP practice situated in highly deprived areas. These are practices that have been unable to reach the national uptake target for breast cancer.

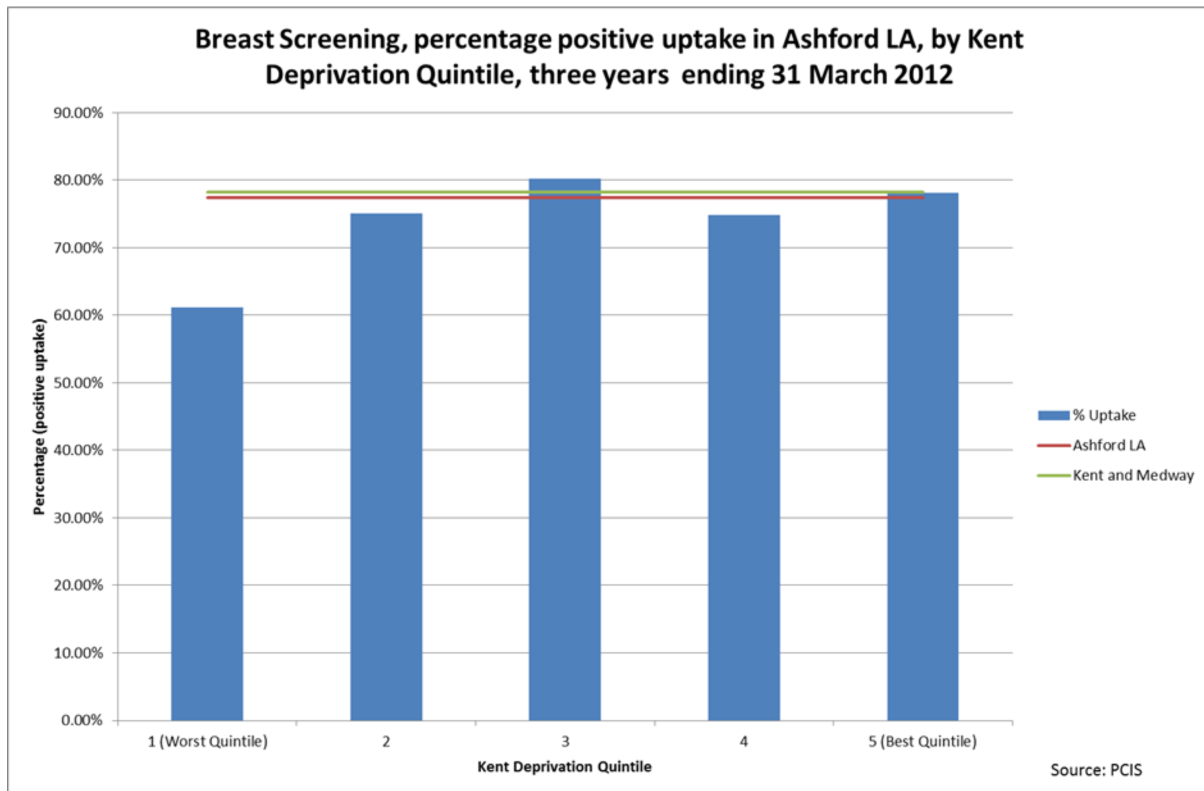


Figure 51: Breast Cancer Screening uptake in Ashford by practice location deprivation quintile

The national target for Bowel Screening uptake is at 60%. Table 52 shows that only half of the practices in the Ashford area have achieved this target.

Bowel Screening percentage positive uptake by practice, 2012/2013

GP Code	GP Name	Number Invited	Number adequately screened	% Uptake
G82748	Musgrove Park Medical Centre	282	129	45.74%
G82049	Hollington Surgery	236	119	50.42%
G82735	St Stephens Health Centre	298	153	51.34%
G82688	Singleton Surgery	143	76	53.15%
G82712	Singleton Medical Centre	117	64	54.70%
G82050	Sydenham House	800	454	56.75%
G82080	Willesborough Health Ctr.	741	427	57.62%
G82094	Charing Surgery	700	425	60.71%
G82730	Kingsnorth Medical Practice	469	290	61.83%
G82142	Wye Surgery	576	362	62.85%
G82053	Woodchurch Surgery	325	206	63.38%
G82087	New Hayesbank Surgery	907	580	63.95%
G82186	Hamstreet Surgery	553	354	64.01%
G82114	Ivy Court	1204	790	65.61%
Ashford LA		**7351**	**4429**	**60.25%**
Kent and Medway		**57785**	**34190**	**59.18%**

Source: PCIS

Table 2: Bowel Cancer Screening uptake

In Figure 52 it is demonstrated that, similar to breast cancer, practices situated in the most deprived areas of Ashford have the worst uptake rates and have not been able to achieve the national target of 60%. Uptake in practices located in areas within the 4th deprivation quintile also had low uptake rates. These are two practices in Singleton that are covering for populations living in very deprived areas of Ashford.

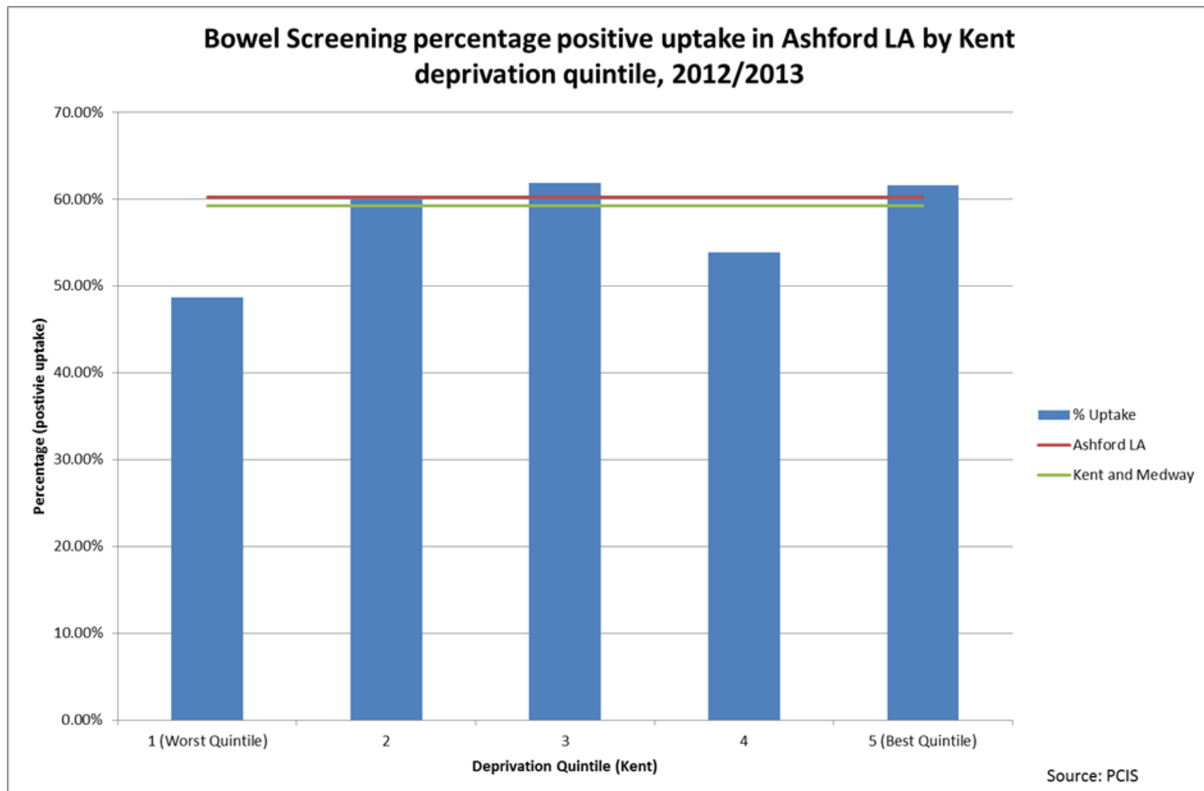


Figure 52: Bowel Cancer Screening uptake in Ashford by practice location deprivation quintile

The national target for the uptake of cervical screening is 80%. Table 3 shows that 6/14 practices (43%) are not achieving this goal.

Cervical Screening, percentage positive uptake, by practice, 5 years ending 30 September 2013

GP Code	GP Name	Eligible Practice Population	Number Screened	% Uptake
G82049	Hollington Surgery	808	618	76.49%
G82050	Sydenham House Medical Centre	3156	2493	78.99%
G82053	Front Road Surgery	783	656	83.78%
G82080	The Willesborough Medical Ctr	3126	2542	81.32%
G82087	New Hayesbank Surgery	4018	3220	80.14%
G82094	The Charing Surgery	2083	1722	82.67%
G82114	Ivy Court Surgery	3173	2530	79.74%
G82142	Wye Surgery	1963	1652	84.16%
G82186	Hamstreet Surgery	1617	1332	82.37%
G82688	Singleton Surgery	955	744	77.91%
G82712	Dr Thomas A	826	670	81.11%
G82730	Kingsnorth Medical Practice	2777	2470	88.94%
G82735	South Ashford Medics	1988	1477	74.30%
G82748	Musgrove Park	1590	1095	68.87%
Ashford LA		**28863**	**23221**	**80.45%**
Kent and Medway		**428450**	**344879**	**80.49%**

Source: PCIS

Table 3: Cervical Cancer Screening uptake

As in other cancer screening programmes, figure 53 shows that uptake for cervical screening is lowest in practices situated in highly deprived areas within Ashford and the target of 80% uptake is not achieved in these practices.

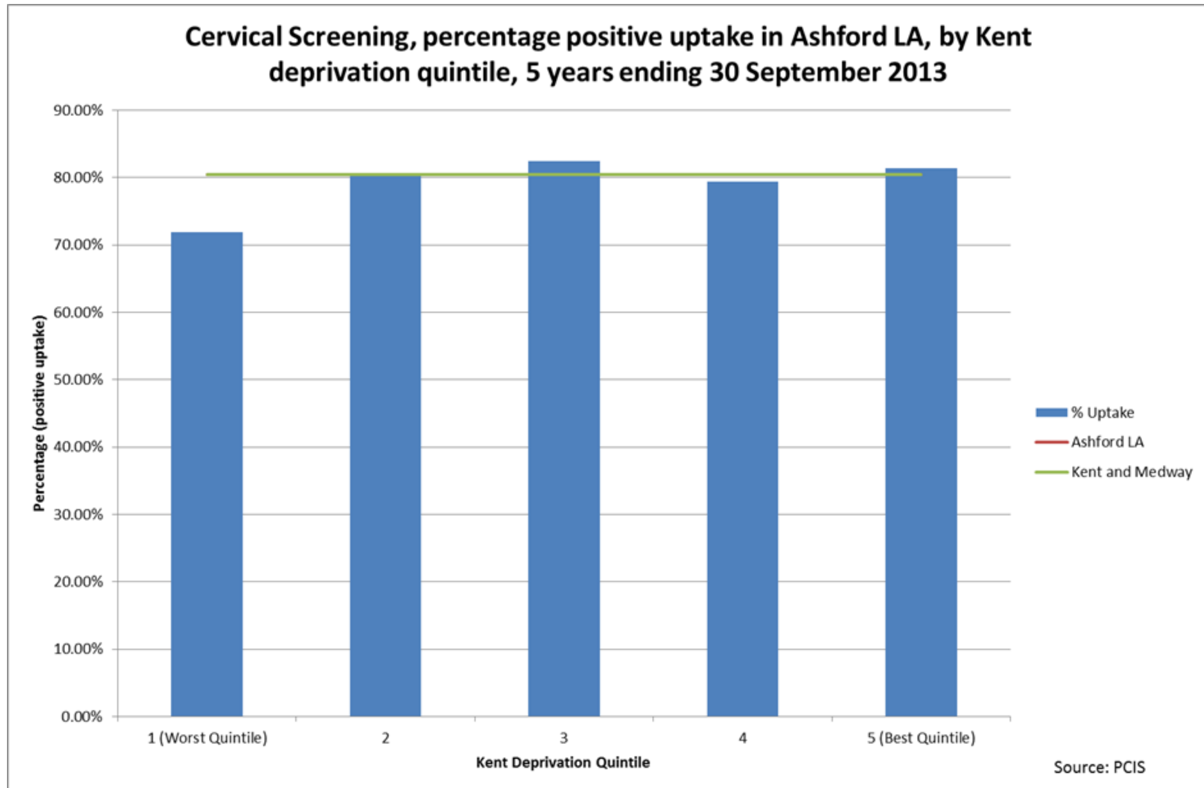


Figure 53: Cervical Cancer Screening uptake in Ashford by practice location deprivation quintile

Overall, there is an uptake of 80.98% for diabetic retinopathy screening in Ashford. This is in line with the national target of 80%. Only 6/14 practices (43%), however, have achieved this target individually and uptake in the majority of practices is less than 80%.

Diabetic Eye Screening, Percentage Positive Uptake, by practice, 2011/12

GP Code	GP Name	Eligible Practice Population	Number Screened	% Uptake
G82049	Hollington Surgery	164	117	71.34%
G82050	Sydenham House Medical Centre	590	464	78.64%
G82053	Front Road Surgery	177	153	86.44%
G82080	The Willesborough Medical Ctr	579	471	81.35%
G82087	New Hayesbank Surgery	595	558	93.78%
G82094	The Charing Surgery	368	295	80.16%
G82114	Ivy Court Surgery	694	553	79.68%
G82142	Wye Surgery	285	233	81.75%
G82186	Hamstreet Surgery	308	235	76.30%
G82688	Dr Setty M V S & Partner	133	90	67.67%
G82712	Dr Thomas A	115	87	75.65%
G82730	Dr Kelly J C & Partners	310	266	85.81%
G82735	South Ashford Medics	283	208	73.50%
G82748	Musgrove Park	205	162	79.02%
Ashford LA		**4806**	**3892**	**80.98%**
Kent and Medway		**77137**	**62018**	**80.40%**

Source: QoF, EKHUFT

Table 4: Diabetic Eye Screening uptake

Public Health Interventions and Recommendations:

- Emergency admissions in Ashford are comparatively lower than in the rest of Kent. This is a positive finding and the trend should be maintained. The King's fund has looked into the effectiveness of interventions that may decrease emergency admissions and stated the following key points[27]:
  - At highest risk for emergency admissions are people living in socio-economic deprivation (including older age, area of residence, morbidity, ethnicity). Commissioners should consider the impact when designing policy around admission rates.
  - Commissioners need to be clear about what admissions are avoidable and how these should be coded and measured.
  - Self-management among people with long-term conditions should be increased. There is evidence that this is particularly effective in patients with COPD and asthma.
  - Quality of primary care is important: continuity of care with a family doctor and out-of –hours primary care arrangements.
- Vaccination uptake rates in Ashford practices are good with most reaching the WHO target of 95% or more. Only few practices in the Ashford area have uptake rates of less than 90% for some vaccinations. Recommendations published by NICE to reduce differences in uptake include[28]:
  - Improve access: extending clinic times; children are seen promptly; clinics are child- and family-friendly
  - Ensure that enough appointments are available
  - Send out tailored invitations and tailored reminders and give out tailored information
  - Give opportunities to discuss concerns
  - Consider home visits to those who have not responded and offer giving vaccinations there and then
  - Check immunisation status of children at every appropriate opportunity
  - Ensure that staff is appropriately trained including communication skills and ability to answer questions
  - School nursing teams should check vaccination status
- Not all practices in Ashford are achieving national targets in screening uptake and inequalities in uptake by deprivation quintile have been shown. Practices serving more deprived populations may need to be more active to increase uptake and reach national screening targets. A systematic review was published by the NHS Centre for Reviews and Dissemination, looking at interventions aiming to increase screening uptake and they make the following recommendations[29]:
  - Efforts should focus on identifying and encouraging attendance among those who have never participated in screening.
  - Current UK practice is to use invitation letters and/or appointments and this is supported by good evidence.
  - Telephone counselling to discuss barriers to screening could be considered.
  - Reducing economic barriers (e.g. free postage or transportation costs) can increase uptake and may be appropriate for specific groups.
  - Healthcare professionals can be prompted either to perform or to recommend screening tests by using reminder systems such as tagged notes.

  Any attempts to increase the uptake of screening should be accompanied by initiatives to increase informed uptake.

[27] http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010_0.pdf
[28] http://www.nice.org.uk/nicemedia/live/12247/45497/45497.pdf
[29] http://www.hta.ac.uk/pdfexecs/summ414.pdf

8 LONG TERM CONDITIONS

Long term conditions (LTCs) are expected to increase as the overall population is ageing because of lower birth rates and longer life expectancy. There will be more demand on health care and emergency hospital admissions may increase as many elderly people are diagnosed with one or more LTCs.

8.1 CORONARY HEART DISEASE

Coronary Heart Disease (CHD) is one of the main causes of death in Ashford and Figure 54 shows prevalence by GP practice in relation to the regional and national average. Prevalence in Ashford is just over 3% and this is slightly lower than the England average. There is great variation between practices. The highest prevalence is in Front Road Surgery with over 5% and the lowest are Practice Dr Setty and South Ashford Medics with less than 2%.

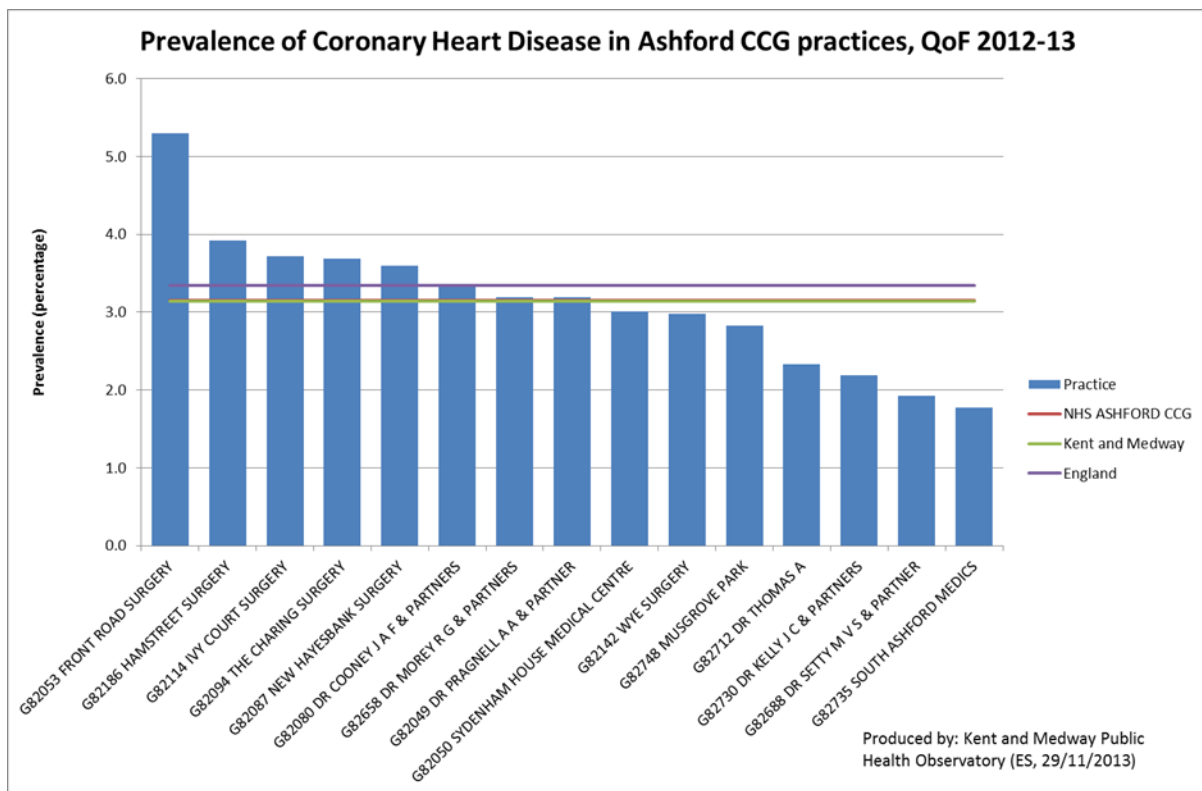


Figure 54: CHD prevalence by GP practice in Ashford compared to regional and national average

Figure 55 shows the emergency admissions presented by GP practice with a green dot showing the cancer prevalence of individual practices.

In 2012/13, the emergency admission rate for CHD in Ashford was between 2-2.5/1,000 registered patients. Practices with high admission rates compared to individual practice prevalence are: Hamstreet Surgery, Willesborough Medical Centre and Hollington Surgery.

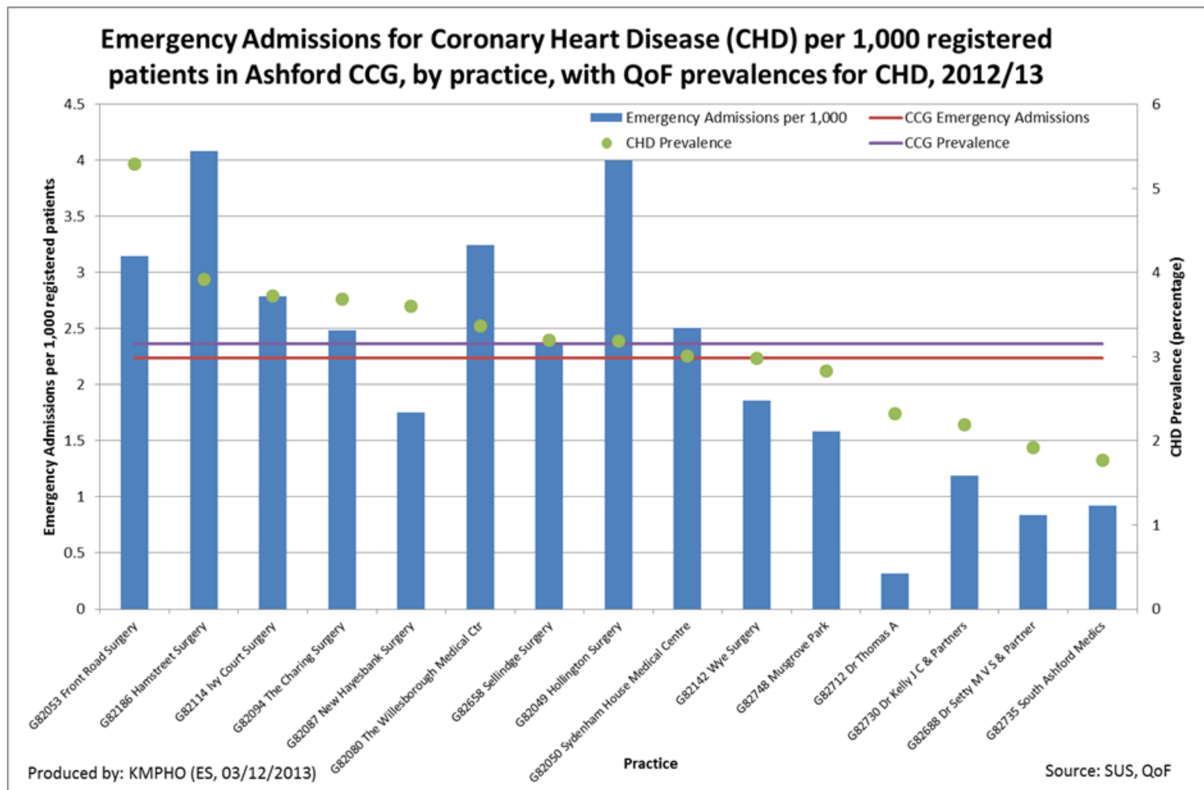


Figure 55: Emergency admissions for CHD by GP practice compared with CHD prevalence

8.2 DIABETES

Diabetes prevalence is around 6% in Ashford, very similar to the England national rate (Figure 56). Variation between practices ranges from over 7% in New Hayesbank Surgery to just over 4% in Practice Dr Kelly & Partners. There is a lower than average prevalence in a further four practices: Practice Dr Setty, South Ashford Medics, Practice Dr Thomas and Wye Surgery.

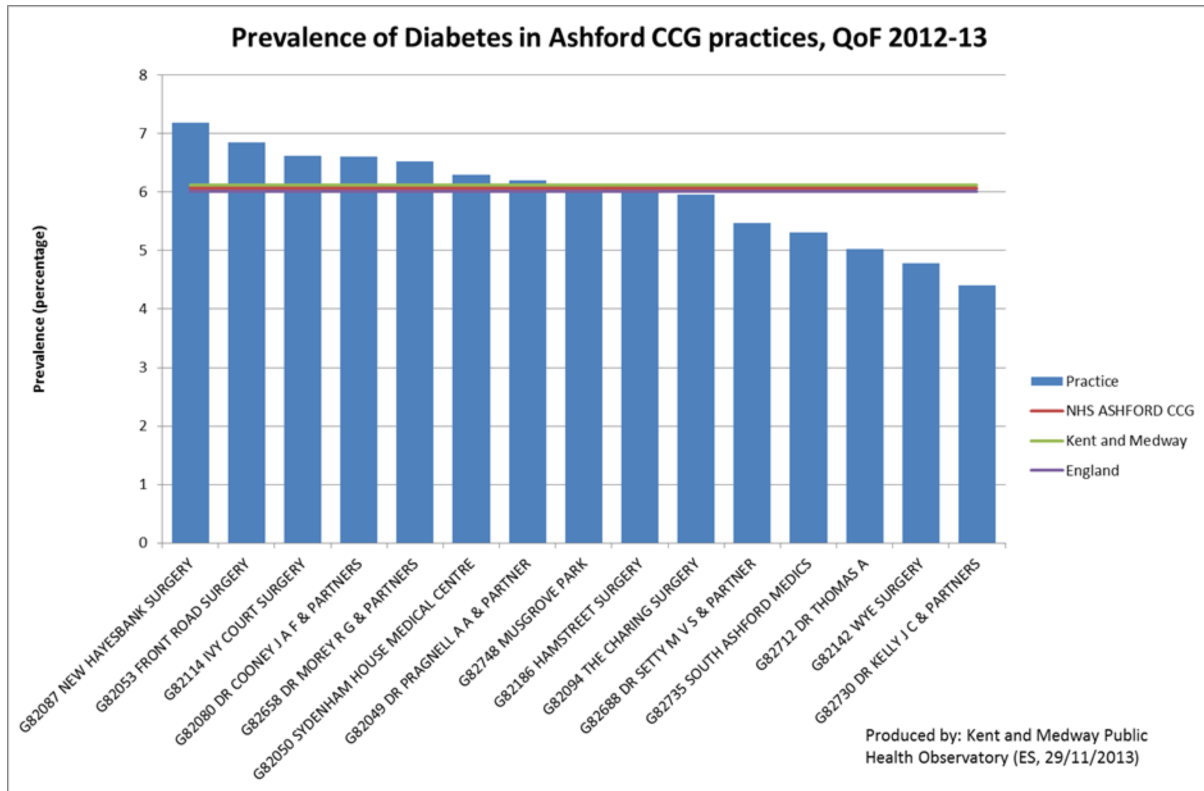


Figure 56: Diabetes prevalence by GP practice in Ashford compared to regional and national average

Emergency admissions for diabetes are quite low with less than 0.6/1,000 registered patients. Two practices had relatively high admission rates compared to their diabetes prevalence: Sydenham House Medical Centre and Practice Dr Setty.

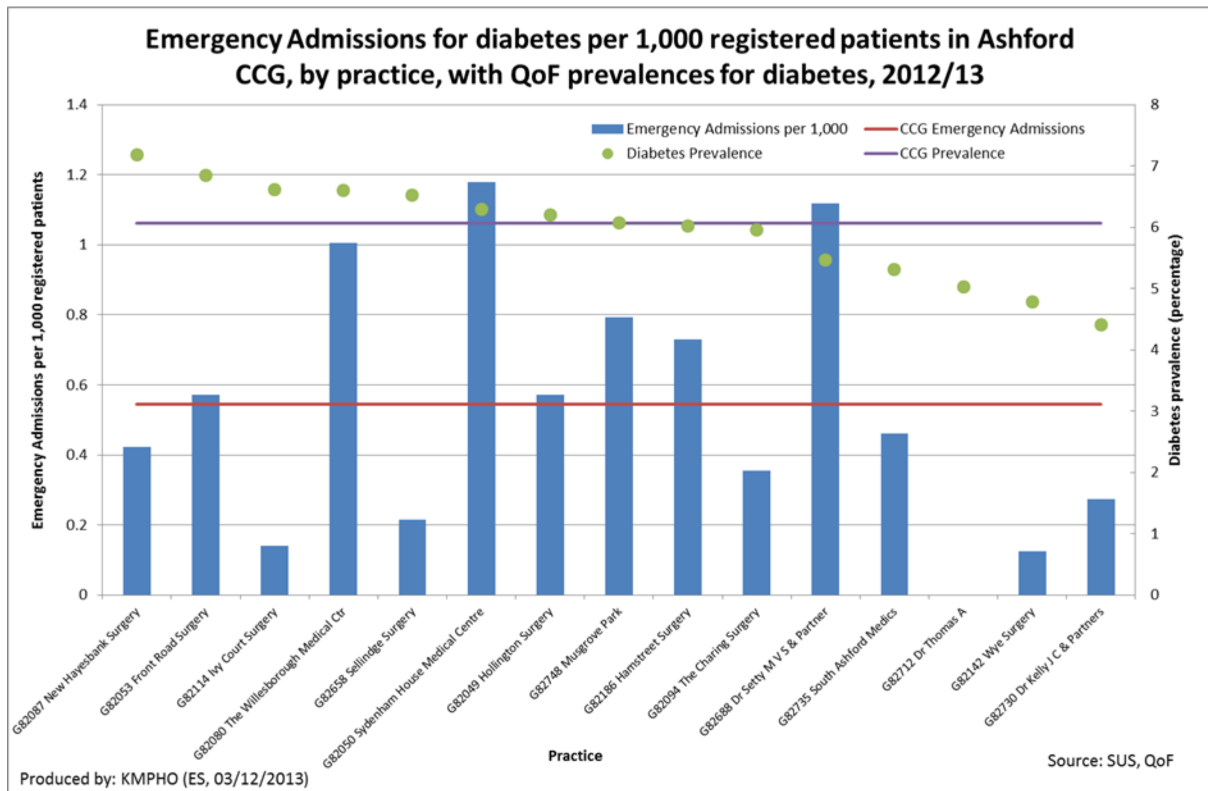


Figure 57: Emergency admissions for diabetes by GP practice compared with diabetes prevalence

Figure 58 shows the prevalence of cancer in Ashford by GP practice. The national average is just under 2%, the average in Ashford just over 2%. The variation in prevalence between practices is large, ranging from less than 1% to over 3%. This fact raises concerns of cancers being undiagnosed in some population groups. Screening uptake was lowest in the practices: St Stephens Health Centre, Singleton Surgery, Musgrove Park Surgery and Hollington Surgery. All these surgeries have cancer prevalence rates below the regional and national average.

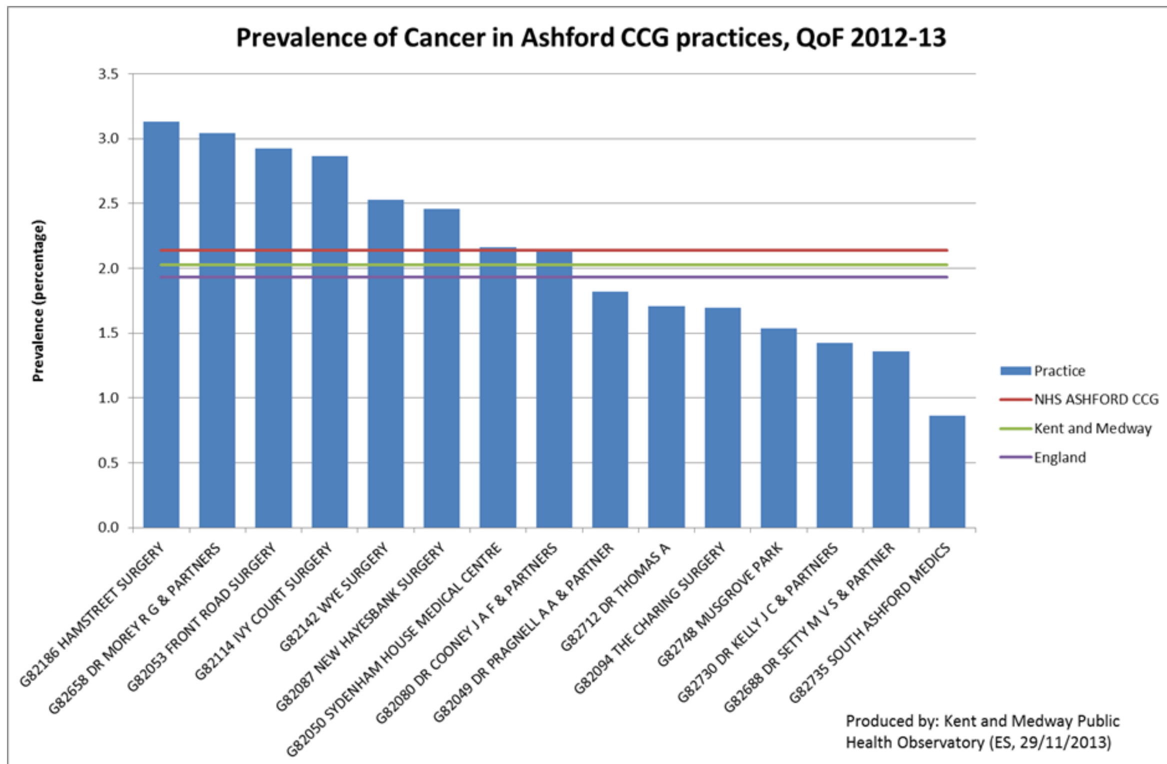


Figure 58: Cancer prevalence by GP practice in Ashford compared to regional and national average

There were, on average, about 1.2/1000 emergency hospital admissions for cancer in Ashford in 2012/13. Practices with a high admission to prevalence ratio are: South Ashford Medics, Dr Setty and Partners, The Charing Surgery and Hollington Surgery (Figure 59).

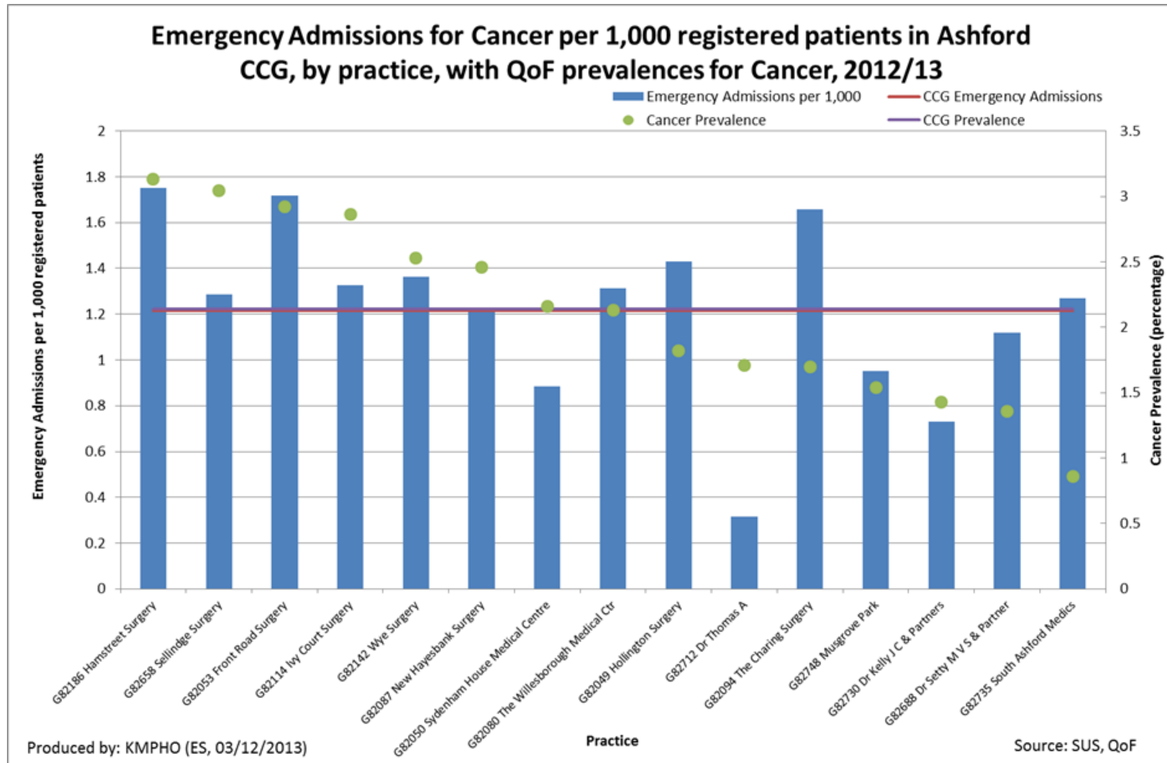


Figure 59: Emergency admissions for cancer by GP practice compared with cancer prevalence

The prevalence of asthma in Ashford is less than 6% which is lower than the England average of around 6%.

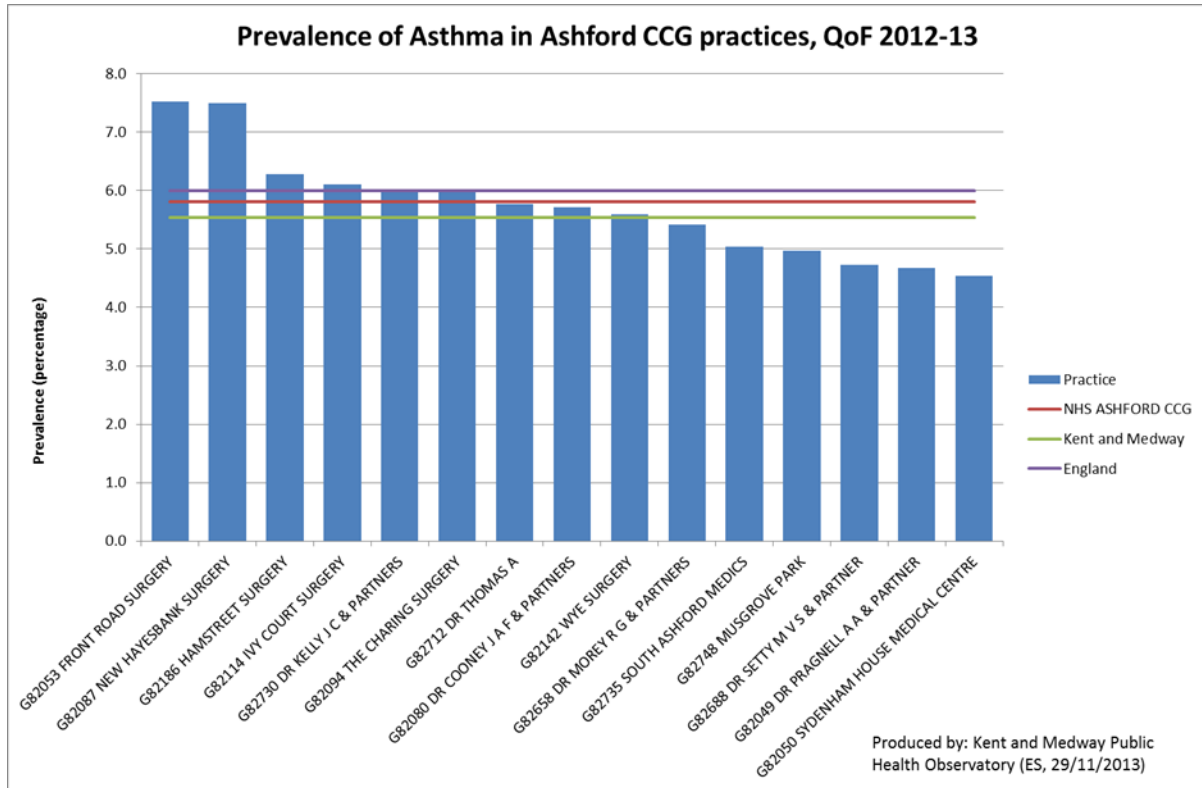


Figure 60: Asthma prevalence by GP practice in Ashford compared to regional and national average

In 2012/13 there were on average just over 0.6/1,000 emergency admissions for asthma in Ashford (Figure 61). Patients registered with South Ashford Medics had a high rate of emergency admissions (over 1,8/1,000), not explained by prevalence of asthma in their practice population.

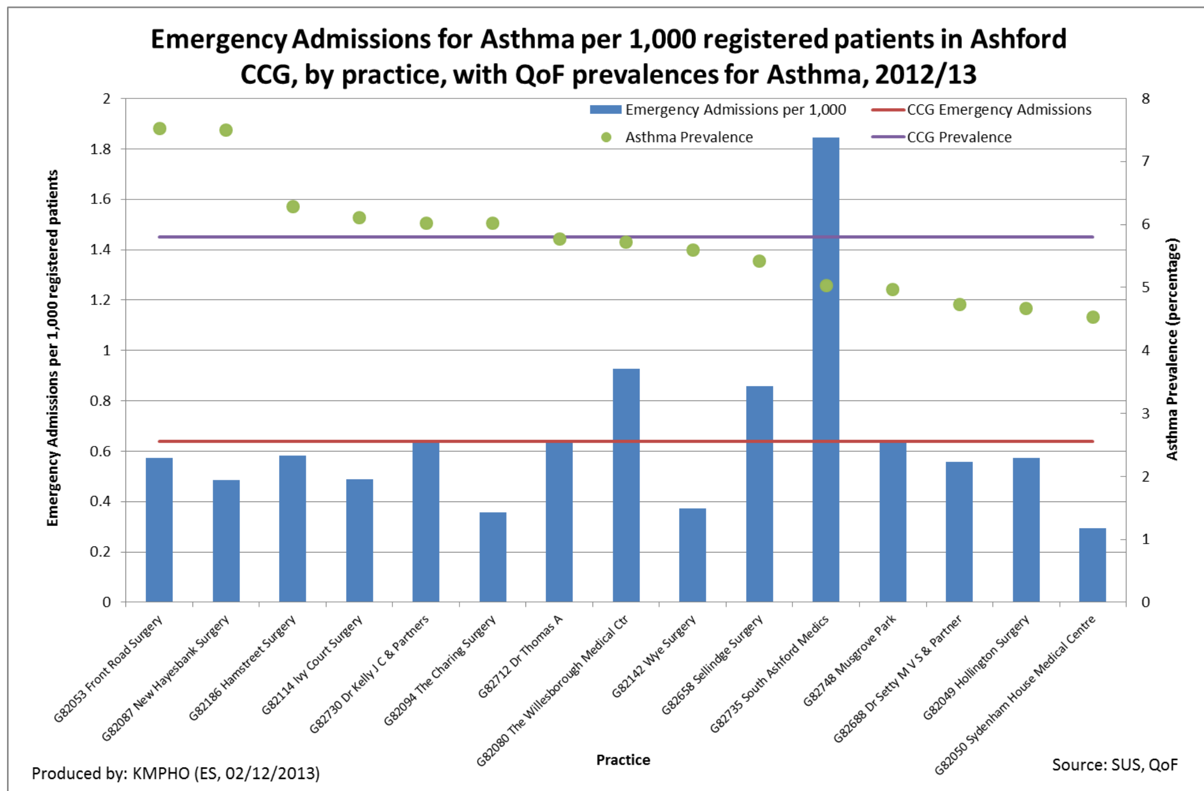


Figure 61: Emergency admissions for asthma by GP practice compared with asthma prevalence

8.5 COPD

The prevalence of COPD lies between 1.5 and 2% in Ashford, similar to rates in England (Figure 62). The prevalence is slightly higher at over 2% in the patient population of Front Road Surgery and Practice Dr Pragnell & Partner. Lower prevalence of COPD of less than 1,5% is seen in the practice population of Sydenham House Medical Centre and Practice Dr Thomas.

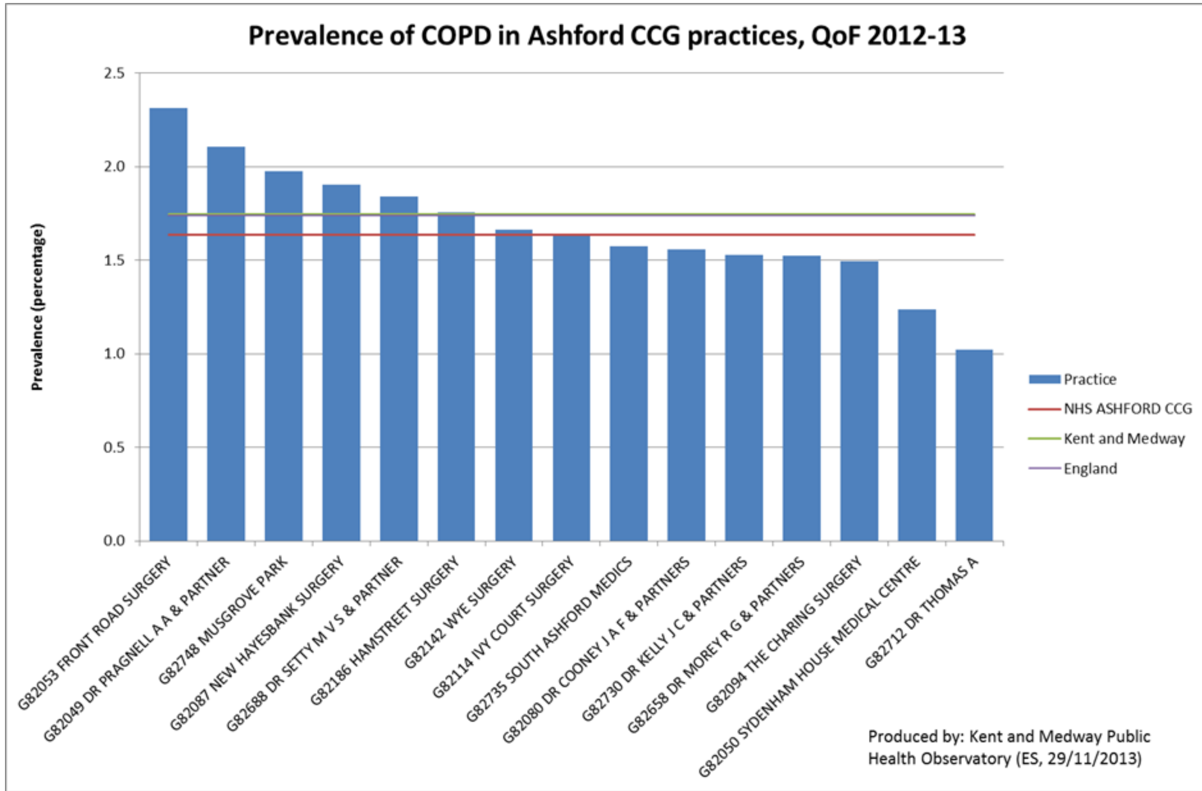


Figure 62: COPD prevalence by GP practice in Ashford compared to regional and national average

Emergency admissions for COPD were on average just over 1.5/1,000 registered patients Figure 63). Five practices had higher rates of emergency admissions: Hamstreet Surgery, South Ashford Medics, Willesborough Medical Centre, Charing Surgery and Sydenham House Medical Centre. This compares to a comparatively low prevalence of COPD in the registered population of Sydenham House Medical Centre (just over 1%).

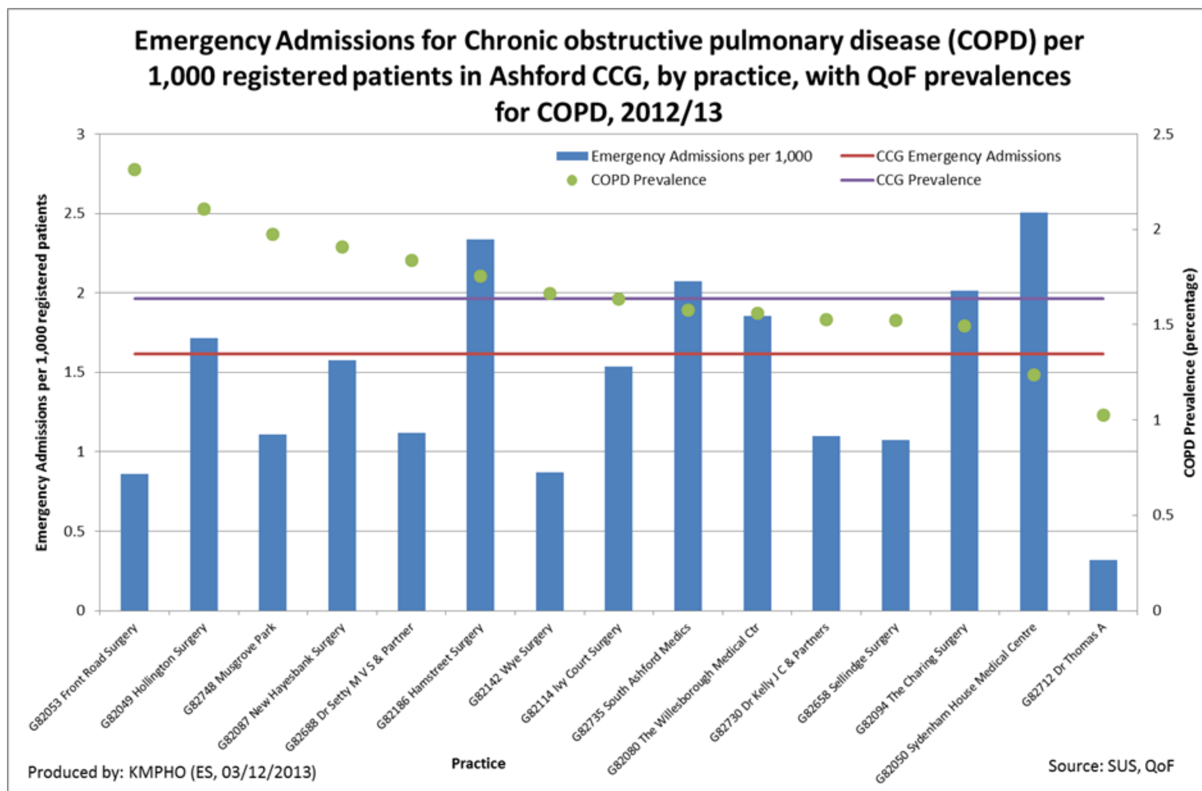


Figure 63: Emergency admissions for COPD by GP practice compared with COPD prevalence

On average, just over 0.6% of GP registered people in Ashford are diagnosed with mental health problems. There is a lot of variation by GP practice (Figure 64). In patients registered with Practice Dr Pragnell & Partner, Musgrove Park Practice and New Hayesbank Surgery the prevalence is over 1%. In the practices Front Road Surgery and Dr Setty the prevalence is less than 0.4%.

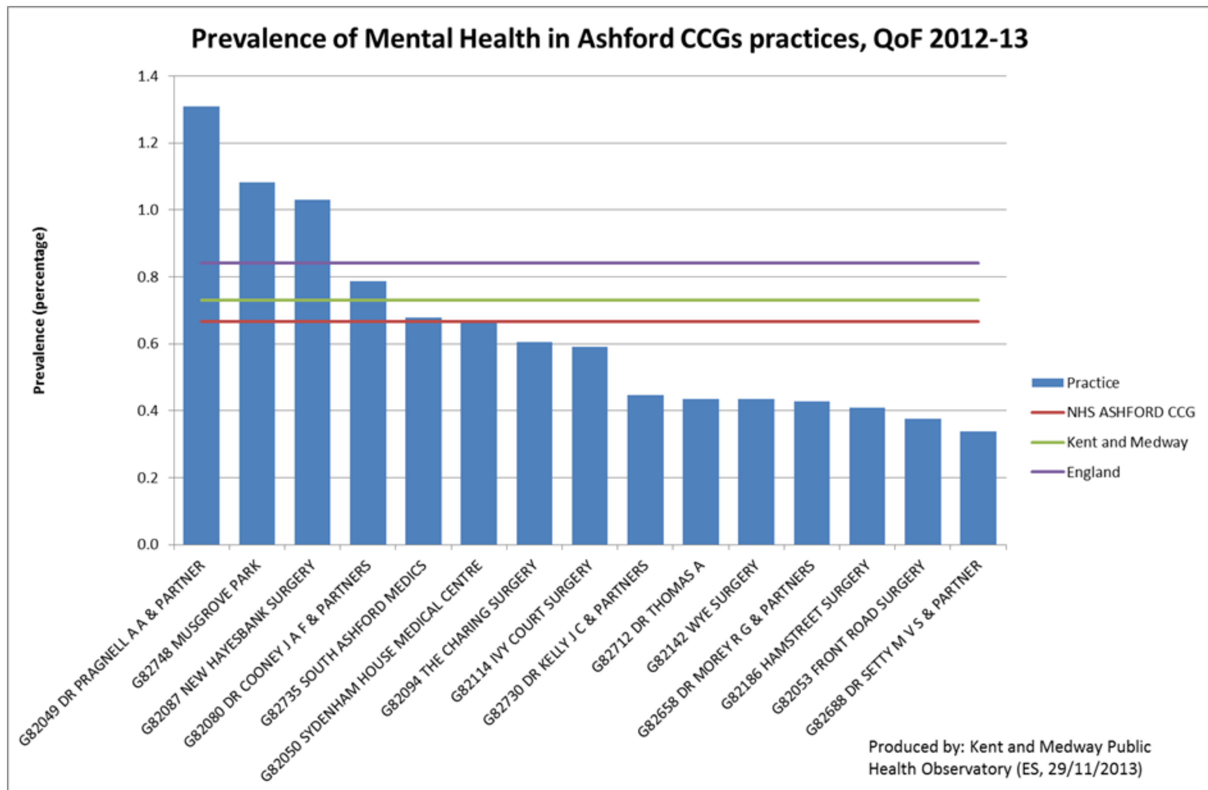


Figure 64: Prevalence of mental Health Problems by GP practice in Ashford compared to regional and national average

There is large variation in emergency admissions for mental health problems. The Ashford average lies around 1-1.5/1,000 registered patients. The highest admission rate has practice Dr Thomas with over 3/1,000 emergencies in 2012/13 whereby prevalence in the practice population is relatively low at around 1%.

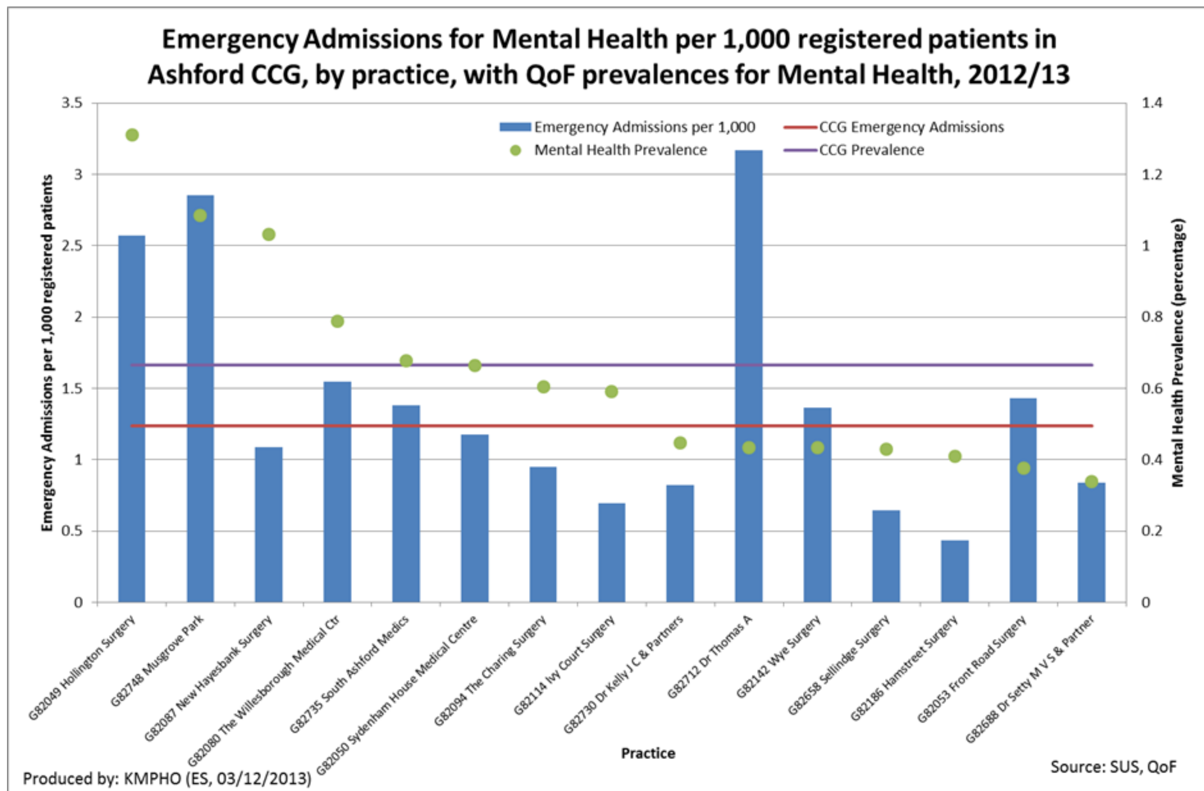


Figure 65: Emergency admissions for mental health problems by GP practice compared with prevalence of mental health problems

Public Health Interventions and Recommendations:

The prevalence of LTCs in Ashford is similar to rates in England. There is, however, some variation by GP practice. Whilst a low prevalence in the population is desirable, under diagnosis of LTCs is a concern. Practices should actively pursue case finding e.g. using the information gathered from health checks. It is expected that prevalence of LTCs will increase initially but this will enable to target prevention programmes to appropriate patient groups.

The National Service Framework (NSF) for Long Term Conditions was published in 2005[30]. It aims to improve health outcomes for people with LTCs and reduce emergency bed days and access to services. The focus is on neurological conditions but it encourages commissioners to use it for non-neurological LTCs as well as it can be applied to a range of conditions. The guidance outlines 11 quality requirements, some of which are:

- A person-centred service: people receive all information about their condition, make informed decisions and are supported in managing the condition themselves where appropriate.
- Early recognition, prompt diagnosis and treatment: prompt access to specialist expertise as close to home as possible.
- Providing equipment and accommodation: appropriate assistive equipment to support people to live independently.
- Providing personal care and support: health and social care services work together to provide care and support.
- Supporting family and carers: access to appropriate support and services that recognise their needs both in their role as carer and in their own right

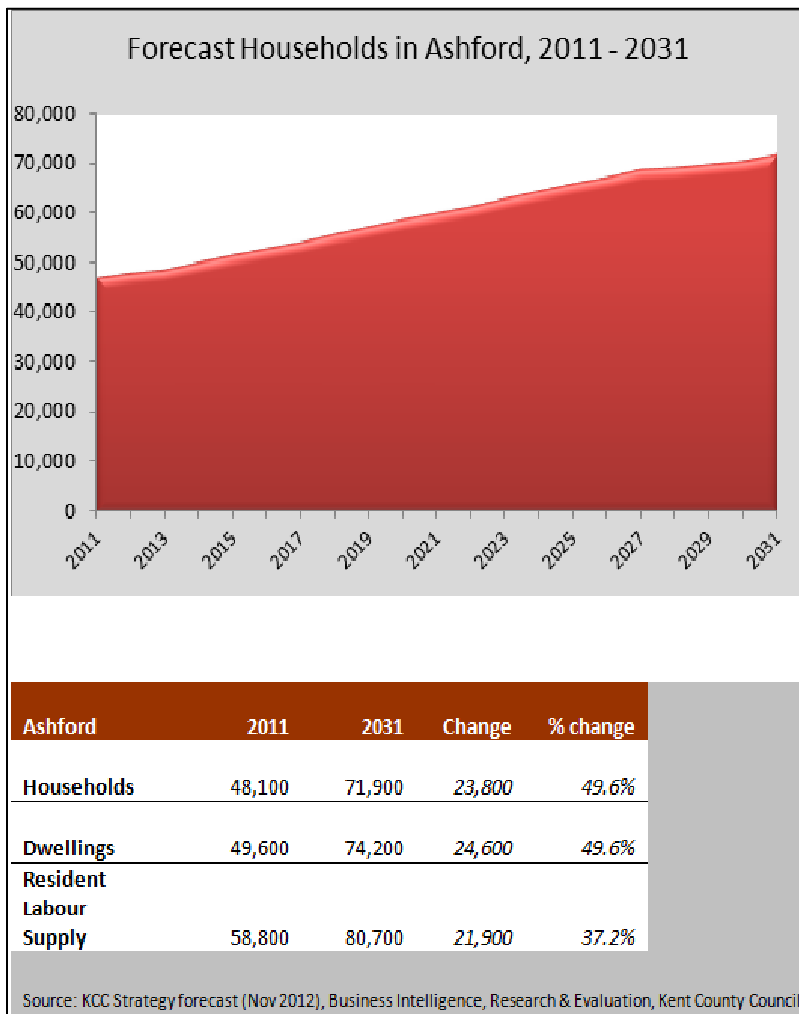
[30]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf

9 ASHFORD'S PLANS FOR EXPANSION

9.1 NEW DEVELOPMENTS

In 2003, the Labour government identified Ashford as a Growth Area in the government's Sustainable Communities Plan. "Following an assessment of social, economic and environmental factors it was concluded that Ashford town had the capacity to provide an additional 31,000 homes and 28,000 jobs over the period 2001 to 2031."[31]

The KCC Strategy Forecast team predicts that between 2011 and 2031, the number of dwellings will increase by 49.6% (Figure 66).



Ashford	2011	2031	Change	% change
Households	48,100	71,900	*23,800*	*49.6%*
Dwellings	49,600	74,200	*24,600*	*49.6%*
Resident Labour Supply	58,800	80,700	*21,900*	*37.2%*

Source: KCC Strategy forecast (Nov 2012), Business Intelligence, Research & Evaluation, Kent County Council

Figure 66: Estimated increase of dwellings in Ashford between 2011 and 2031

Plans have been published by Ashford Borough Council that, a) describe developments in Ashford town centre with a potential of 2,500 further homes, b) identify development sites within Ashford urban area aiming for 3,500 new homes and c) give details of urban extension areas: Chilmington Green and Cheeseman's Green with plans for about 10,000 new homes on these sites altogether[32].

[31] http://www.ashford.gov.uk/core-strategy-2008
[32] http://www.ashford.gov.uk/?page=local-plan-documents

9.2 IMPLICATIONS ON PUBLIC HEALTH

Rapid population growth has significant impacts on Public Health and whilst developments are at the planning stage, it is important to recognise "the critical link between our built environments and public health. How well we plan land use, amenities, transportation, economic development and natural resource protection will have dramatic effects on our communities far into the future".[33]

1. Primary care

    a. Access to General Practitioners
    Good access to primary care is important because it has positive effects on the health of individuals. Gravelle et al[34] looked at self-reported health in data obtained from the Health Survey for England. They found that an increase in GP supply increased the probability of reporting very good health significantly Access is firstly related to availability. GP provision can vary widely within the UK as the BBC reported a few years ago[35]. Adding new developments to a confined area in Ashford will need careful consideration to see if more GPs are needed. Oversubscribed practices will have a negative impact on access with fewer appointments available. Any new practice should be well connected to public transport systems.

    b. Prevention of diseases
    Primary care provision is crucial for disease prevention in the population. Newly built communities will need to be included in prevention programmes including screening, vaccination, health checks etc. Capacities need to be reviewed and additional measures may be needed to include 'hard to reach' population groups.

2. Encouraging physical activity

    a. Open spaces and recreation grounds
    Any new development should include open spaces and/or parks to give residents the opportunity to exercise (walking, jogging, etc.). Children can play in safe areas and explore the natural environment.
    Apart from physical health benefits, spending time outside in green spaces and connecting with other residents can reduce stress and have a positive impact on mental health.

    b. Street design
    Pedestrians and cyclists need to be safe; therefore roads should have secure pavements and dedicated cycle lanes. Traffic calming interventions are important and have been shown to reduce accidents, air pollution and traffic noise.[36]

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[33] http://www.healthycommunitiesbydesign.org/
[34] Gravelle H, Morris S, Sutton M. Are family physicians good for you? Endogenous doctor supply and individual health. Health Serv Res 2008;43:1128–44
[35] http://news.bbc.co.uk/1/hi/health/4228745.stm
[36] http://www.its.leeds.ac.uk/projects/primavera/p_calming.html

c. Amenities
   Amenities that are within walking or cycling distance may avoid car journeys and further contribute to healthy activities. This should be taken account of at the development stage of new communities.

3. Promoting healthy eating

   a. Fresh produce
      Fruit and vegetable consumption is important and should be available locally and fresh. This may be in supermarkets, local farm shops or regular markets. Developers need to make sure that spaces needed for these sellers are accommodated in their plans.

   b. Community gardens
      Community gardens and farms bring lots of benefits to a community: They produce fresh food and encourage healthy diets. They also positively impact on community cohesion, physical activity, enable learning of new skills and improve mental health.[37]

Conclusion and Recommendations

Rapid growth of the population in Ashford invariably impacts on Public Health. This brings opportunities to positively influence the planning stage of new developments.

- There should be adequate GP provision to ensure good access to preventative health programmes.
- Physical activity should be encouraged and made easier by including open spaces and recreation grounds within the design of new estates. Street design should be safe for cyclists and pedestrians and amenities should be local to avoid car journeys.
- The promotion of healthy eating should be supported with opportunities to obtain healthy foods locally and, ideally, encourage own produce in gardens/community gardens.

Further benefits from these interventions would be expected, including an improvement in social cohesion, development of a community spirit and positive influences on people with mental health problems.

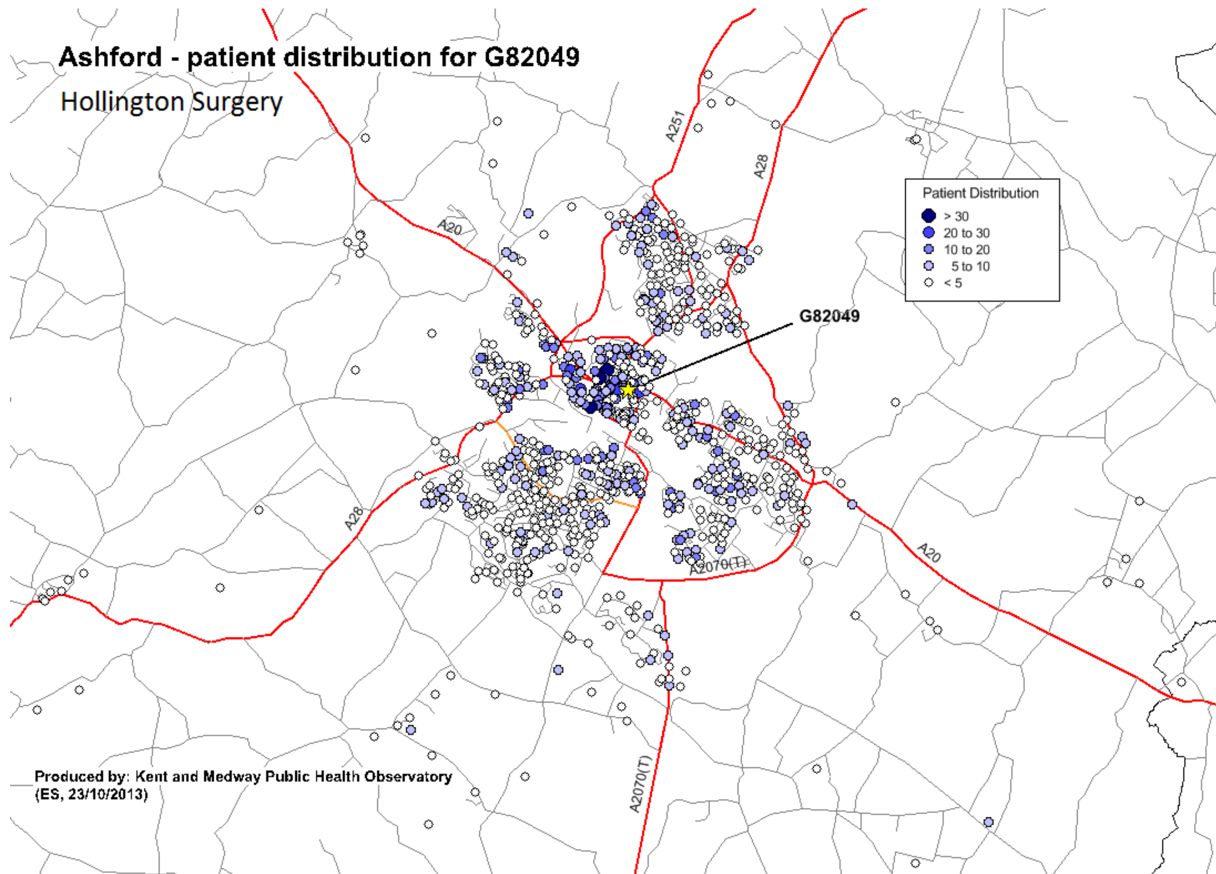
[37] http://www.farmgarden.org.uk/farms-gardens

Practice Level Information – Ashford CCG

Patient Distribution Maps and APHO Practice Profile

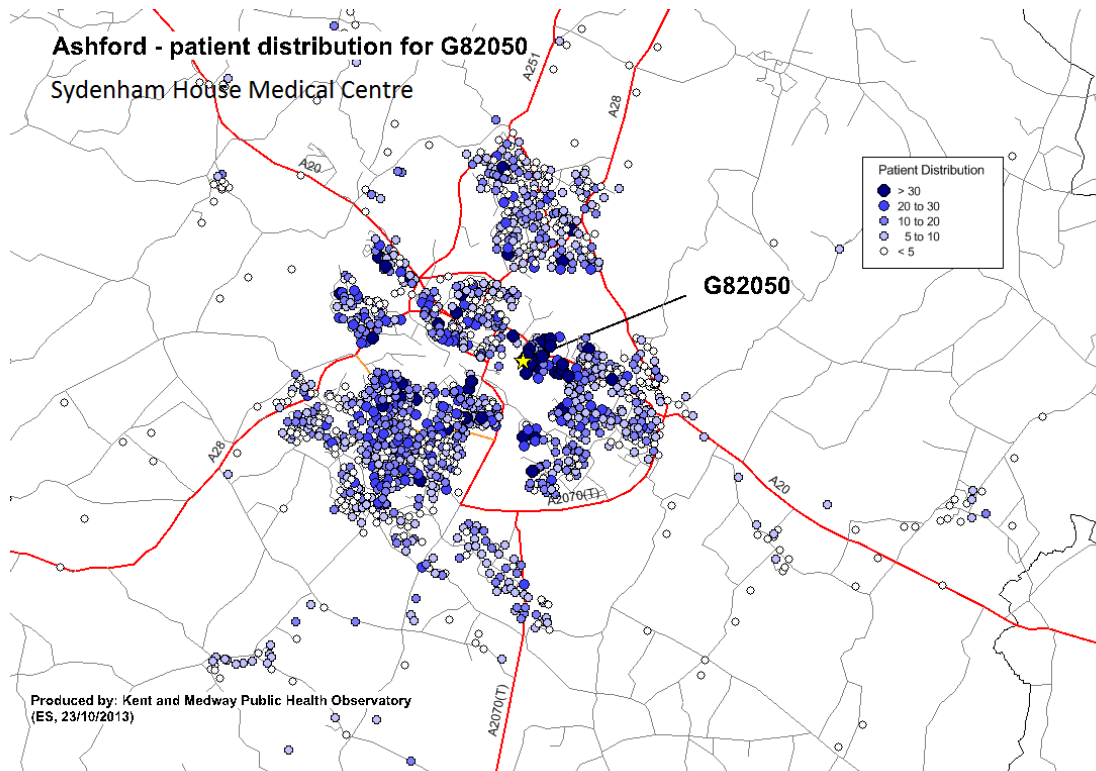
G82049 – Hollington Surgery

http://www.nepho.org.uk/gpp/index.php?CCG=09C&PracCode=G82049



G82050 – Sydenham House Medical Centre

http://www.nepho.org.uk/gpp/index.php?CCG=09C&PracCode=G82050



G82053 – Woodchurch Surgery

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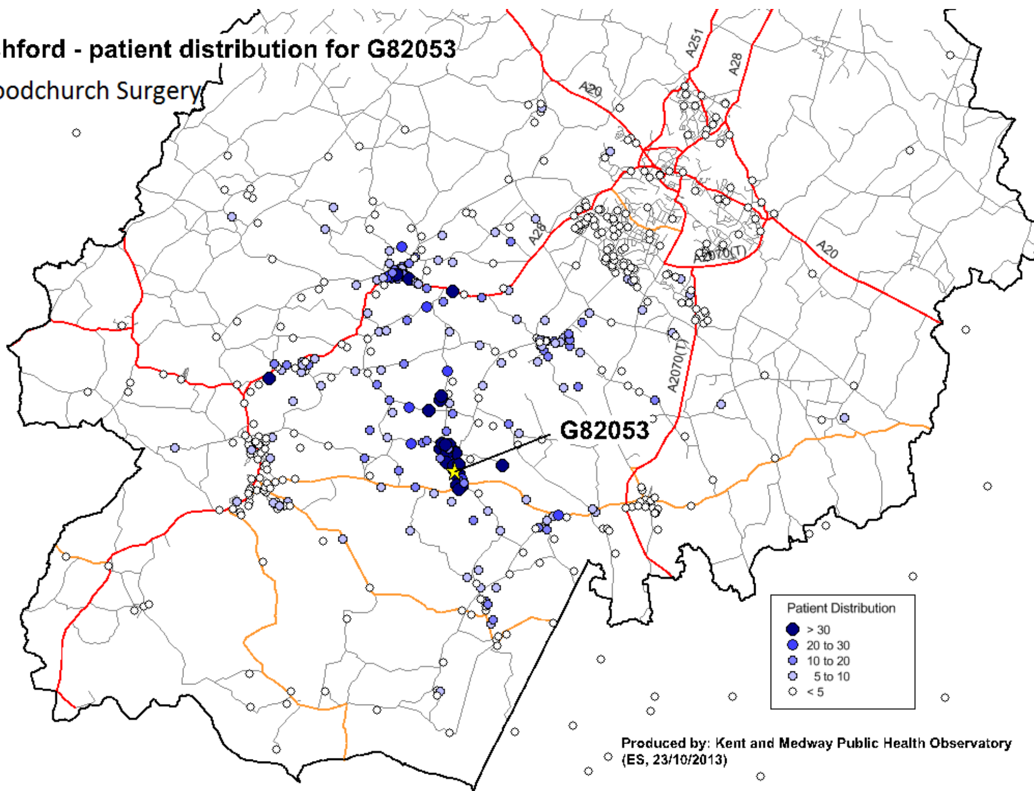
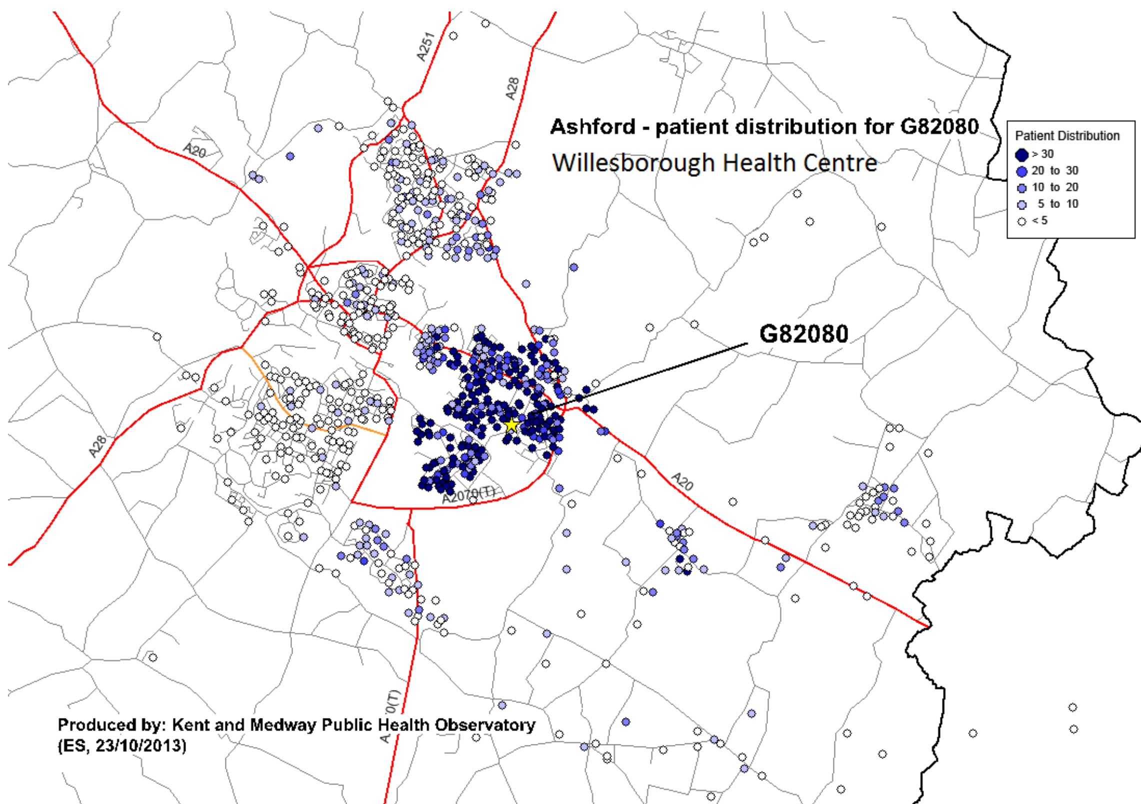


G82080 – Willesborough Health Centre

http://www.nepho.org.uk/gpp/index.php?CCG=09C&PracCode=G82080



G82087 – New Hayesbank Surgery

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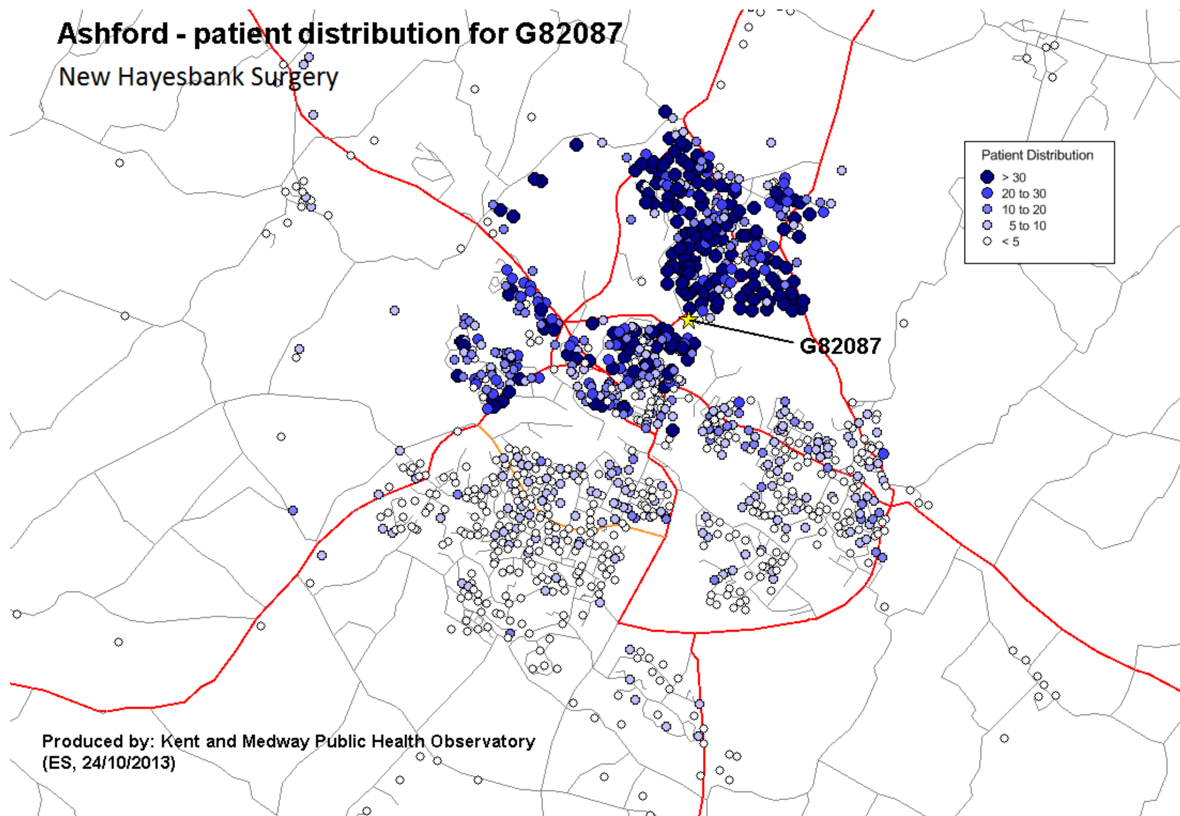
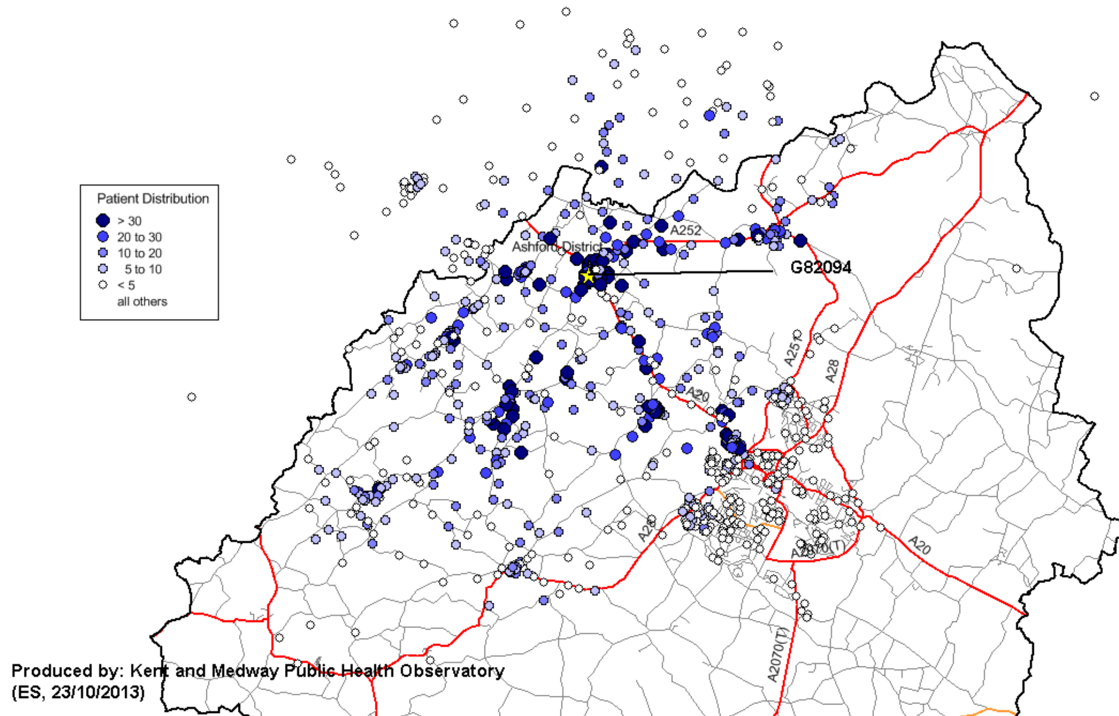


G82094 – Charing Medical Partnership

http://www.nepho.org.uk/gpp/index.php?CCG=09C&PracCode=G82094

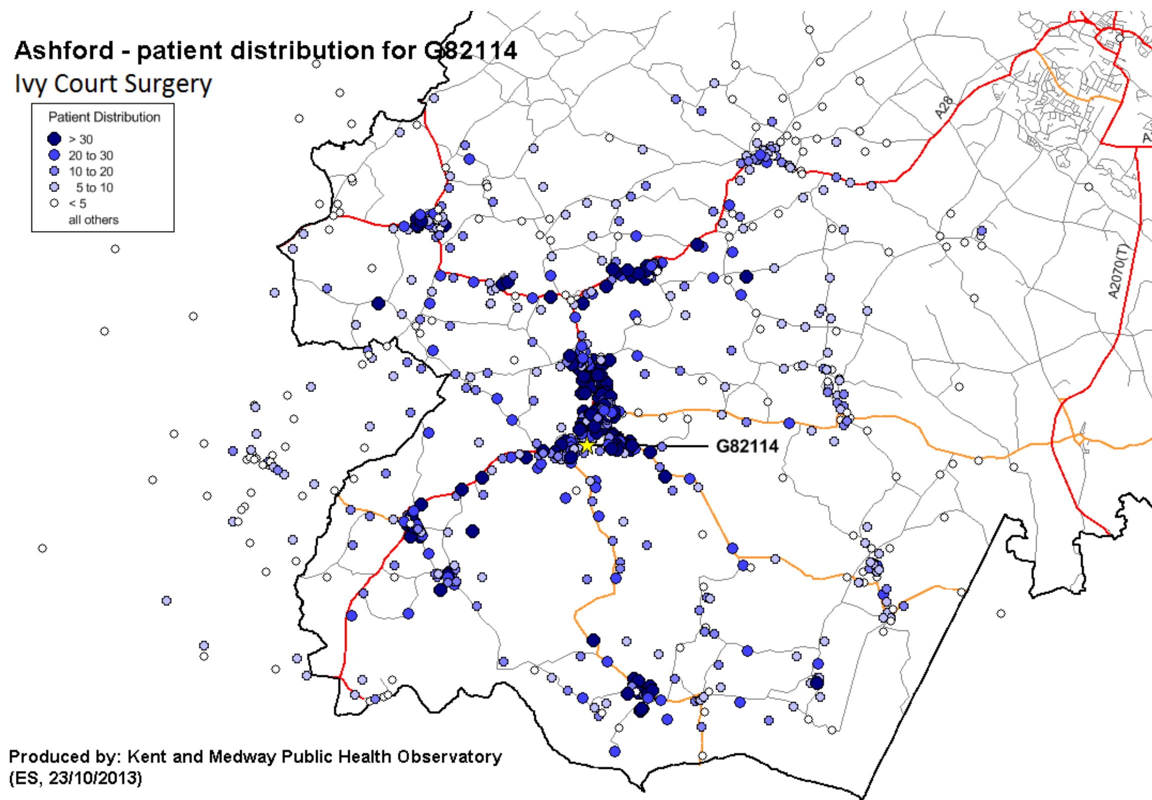
Ashford - Patient Distribution for G82094

Charing Medical Partnership



G82114 – Ivy Court Surgery

http://www.nepho.org.uk/gpp/index.php?CCG=09C&PracCode=G82114



G82142 – Wye Surgery

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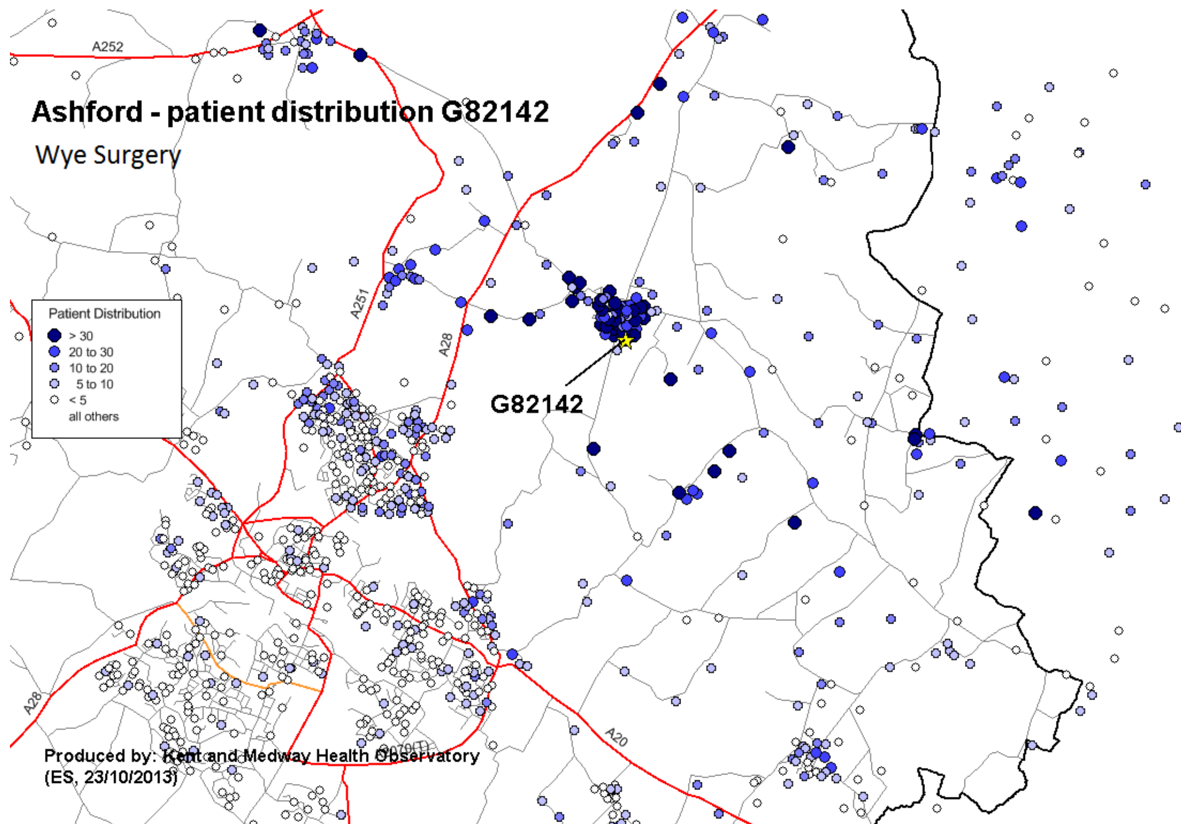

G82186 – Hamstreet Surgery

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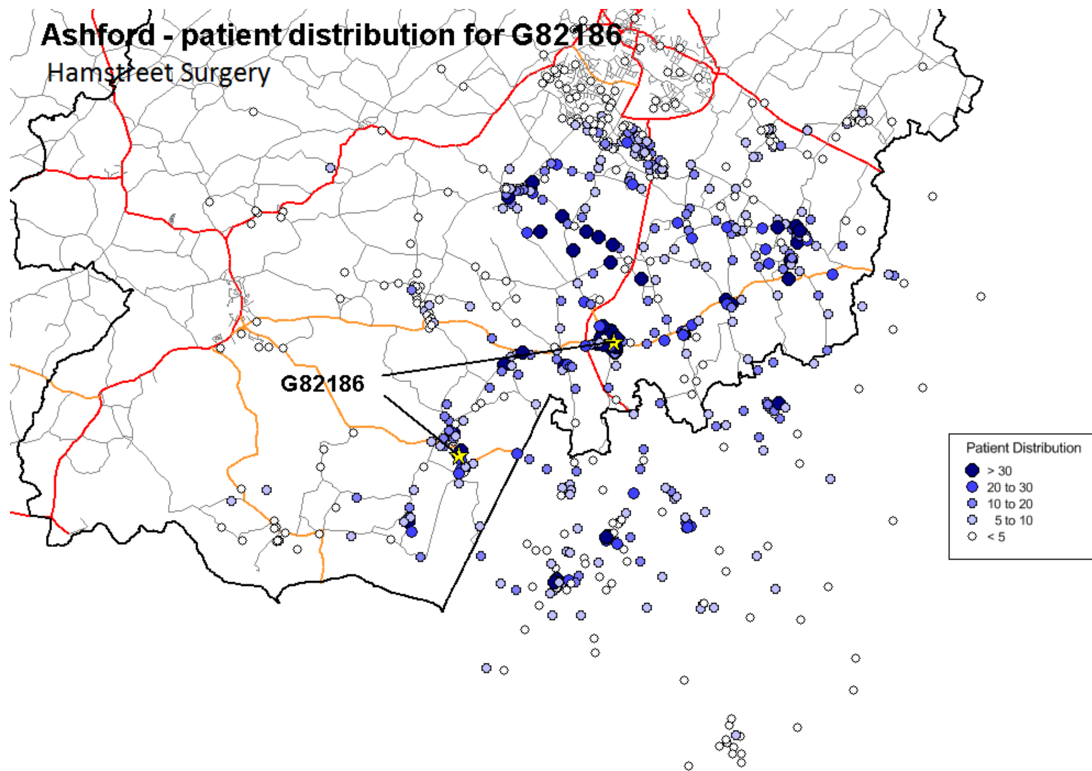

G82658 – Sellindge Surgery

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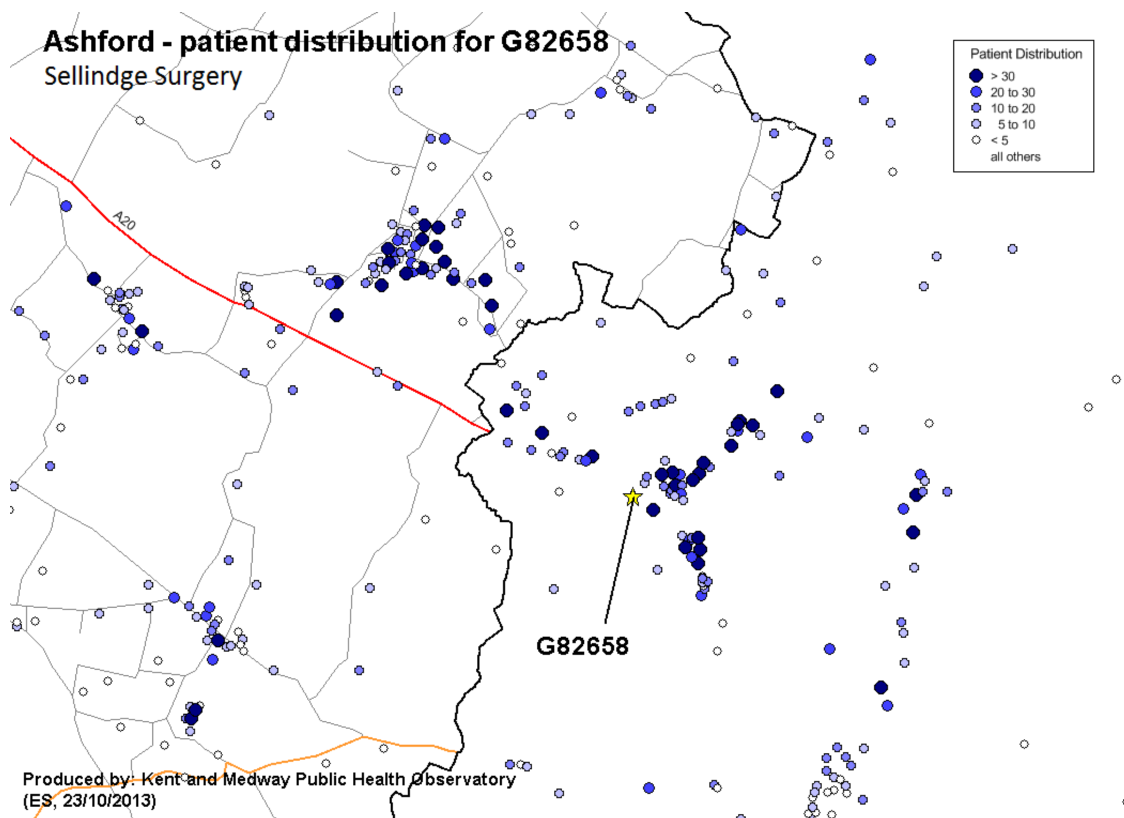

G82688 – Singleton Surgery

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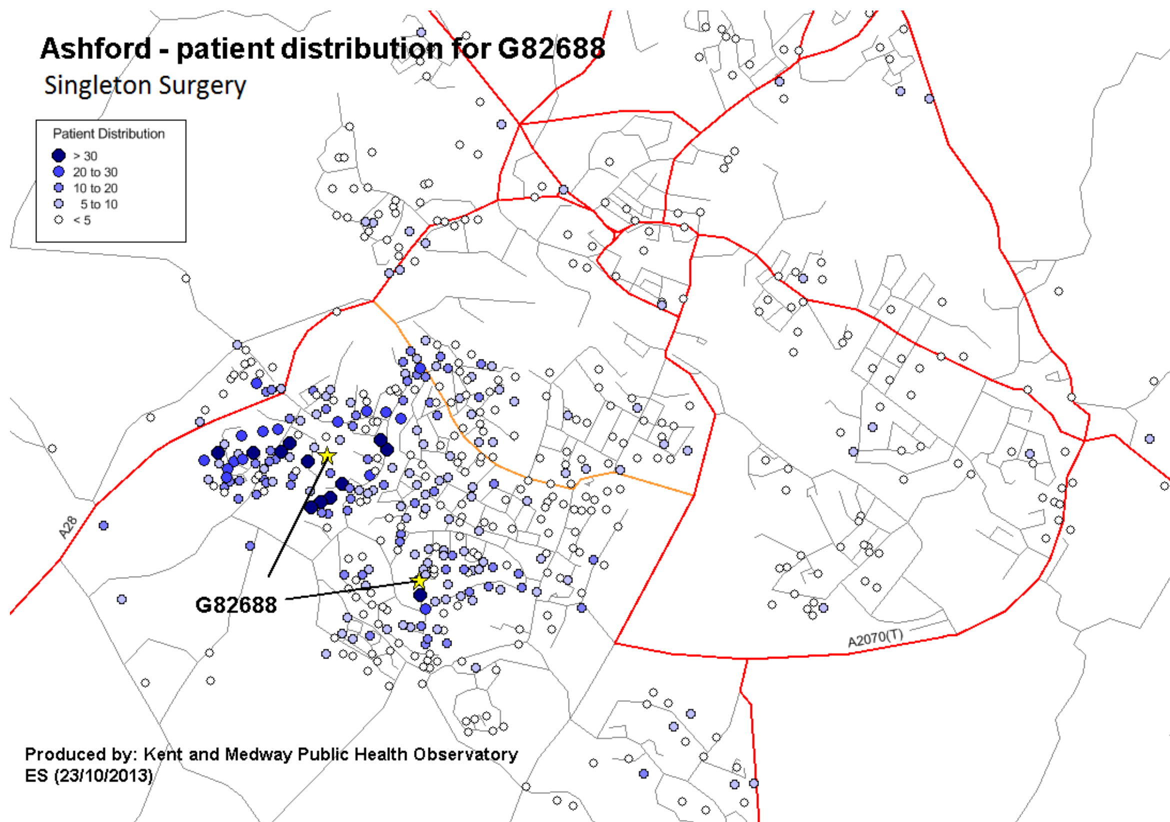

G82712 – Singleton Medical Centre

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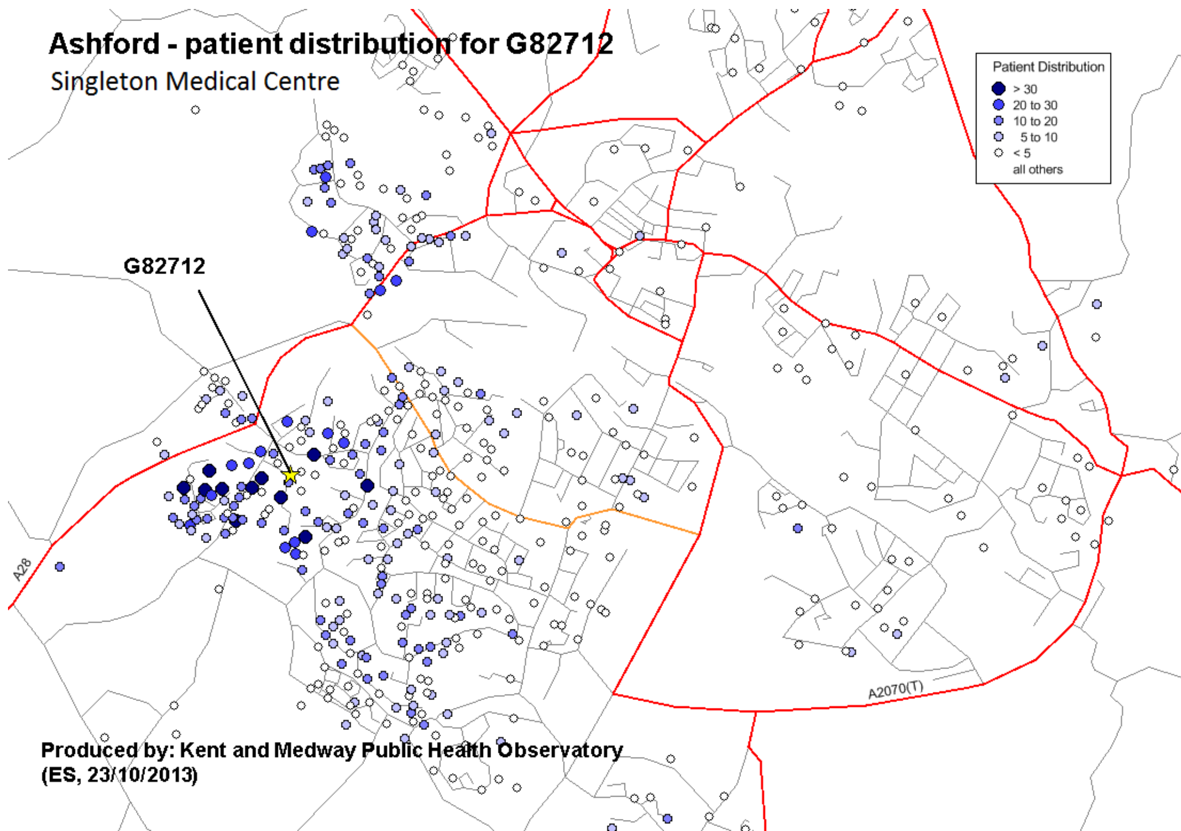

G82730 – Kingsnorth Medical Practice

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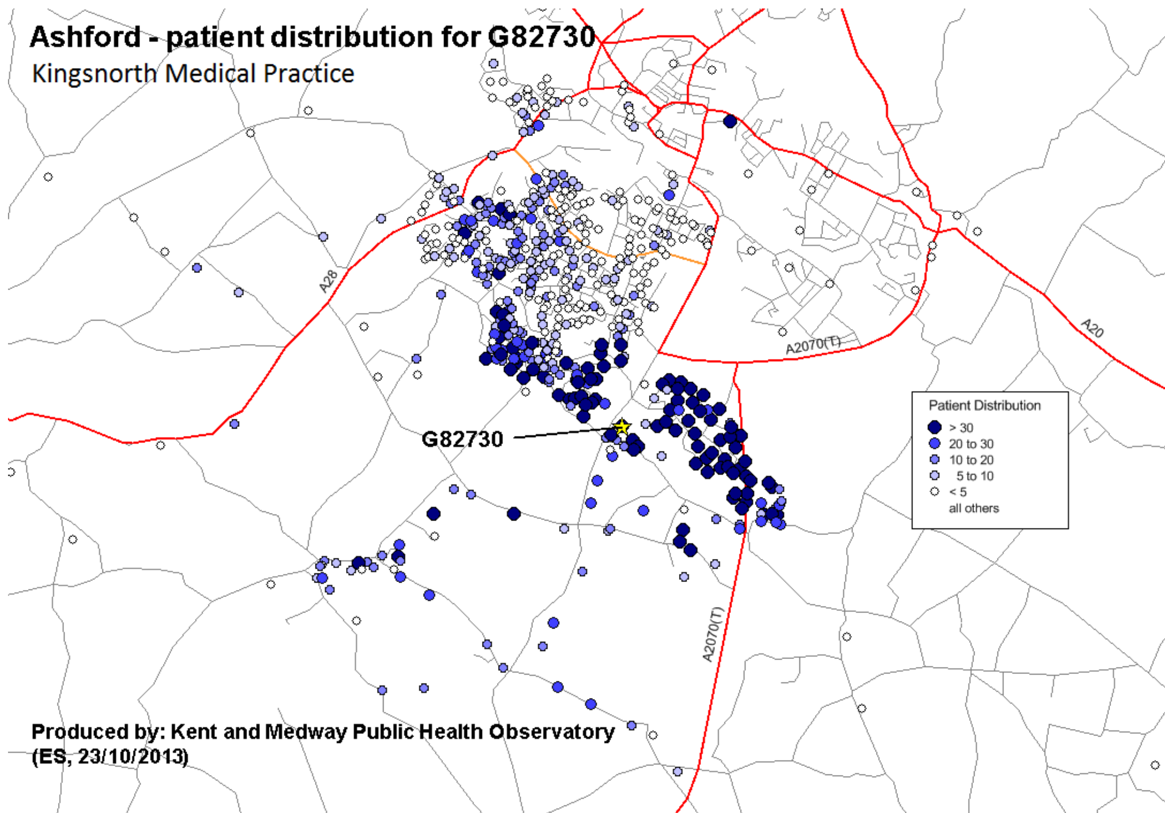

G82735 – St Stephens Health Centre

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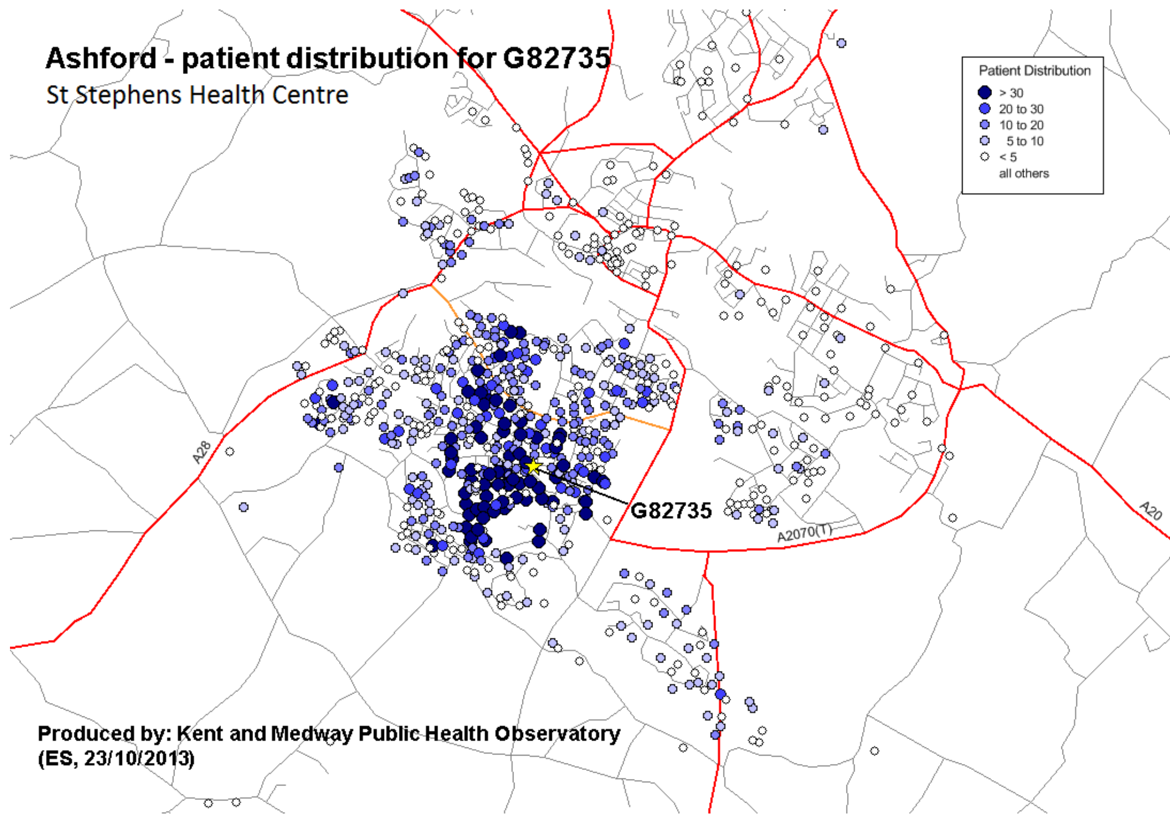

G82748 – Musgrove Park Medical Centre

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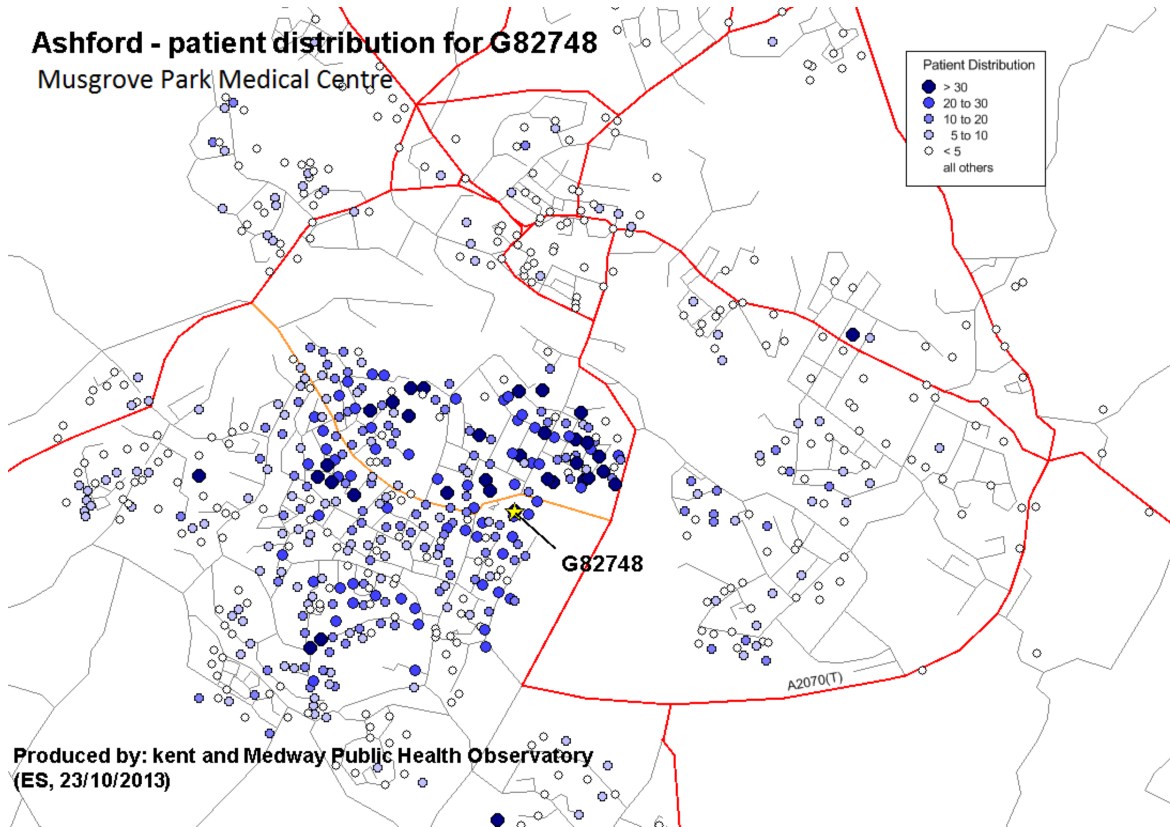
Ashford - patient distribution for G82748
Musgrove Park Medical Centre
Patient Distribution
> 30
20 to 30
10 to 20
5 to 10
< 5
all others
G82748
A2070(T)
Produced by: kent and Medway Public Health Observatory
(ES, 23/10/2013)