Ashford Health and Wellbeing Board Priorities

1. BACKGROUND

A list of indicators was presented to the Ashford Health and Wellbeing Board (AHWB) meeting on 20th January against which Ashford was performing significantly worse or worse as compared to the comparator CCGs, South East region, and England. Following this meeting these indicators were discussed at the Lead Officer Group where the following two priorities were agreed to be put forward for approval by the Board.

- Smoking
- Obesity (Adults and Children)

The three main principles underpinning these priorities will be:

- Reduction in health inequalities
- Early diagnosis
- Early help and co-design.

Mental health is now the commonest single cause of disability adjusted life years lost in the Western world ,23% compared to 16% each for cardiovascular disease and cancer. It affects 18% of working age adults at any one point in time and over a third of adults during the course of a year. Mental health is responsible for more sickness absence than any other illness. Mental health problems represent the largest single cost to the NHS (11% of current spending). Most mental, emotional or psychological problems, which fall short of diagnosable mental illness, together account for more disability than all physical health problems put together. In addition mental illness is an important cause of social inequality, violence and unemployment as well as a consequence. Amongst the main causes of death for people with a mental health condition are cardiovascular disease, cancer and pulmonary disease. Those affected by these conditions die 20 years earlier than a person with no mental illness on average.

A review of the mental health data for Ashford has shown that it is not significantly different to its comparator areas therefore mental health doesn't merit becoming a priority. Work is being done in the mental health subgroup of the LCPG Local Childrens Partnership Group and in the CCG which will address this area of need.

2. PRIORITY 1: SMOKING

2.1 Reasons for selecting smoking as a priority

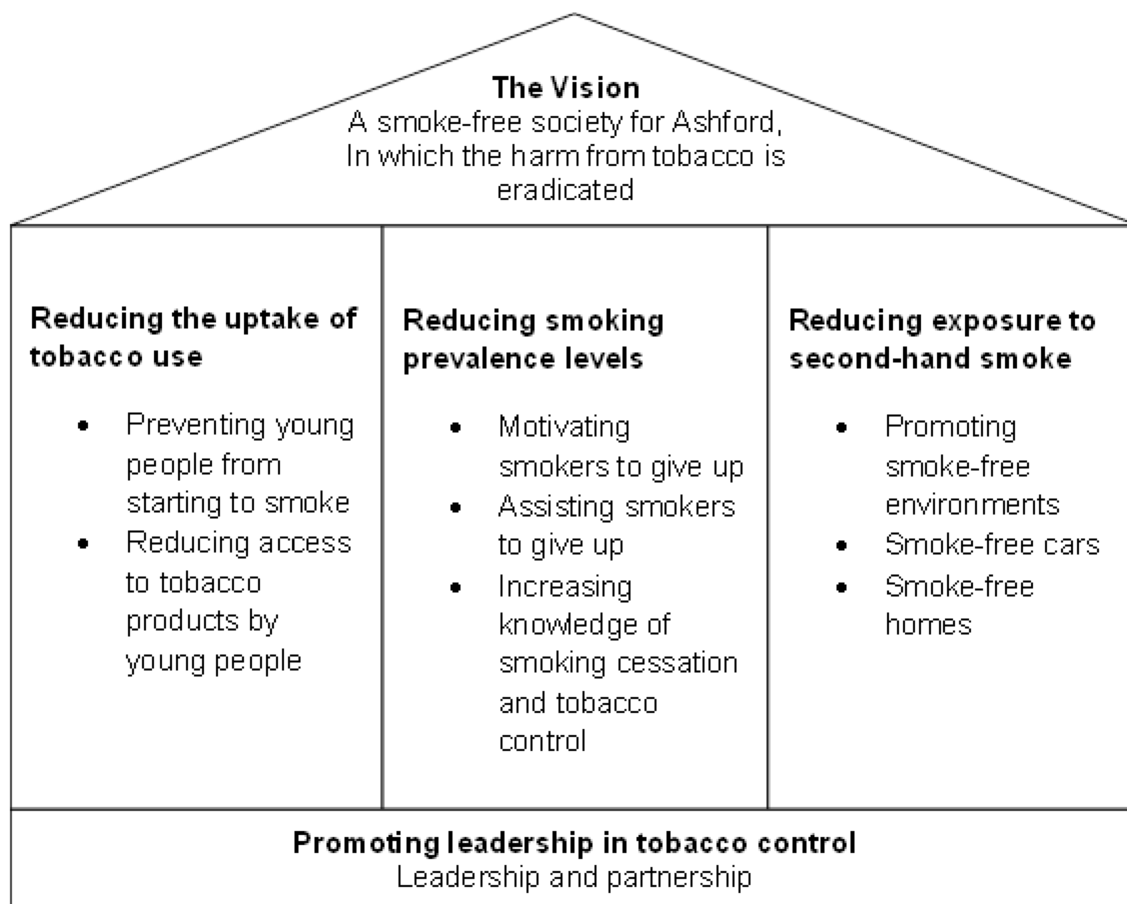
Smoking is still the leading cause of preventable death and disease in the UK, responsible for more deaths than obesity, alcohol, drugs and HIV combined (ASH 2013). About half of long term smokers will die prematurely losing, on average, about 10 years of life. In Ashford, there were 480 estimated deaths attributable to smoking per 100,000 population aged 35+ between 2011 and 2013 (Tobacco Control Profiles 2014).

In 2014 smoking prevalence reduced to 19% in Kent in line with, but slightly above, the national rate of 18.4%. The smoking prevalence in Ashford amongst persons aged 18 years and over is 26.4% and amongst the routine and manual workers it is 42.1%. Prevalence of smoking among persons aged 18 years and over who have never smoked is 38.9%. All of these indicators are significantly worse when compared to the South East Region and England. Smoking in Kent costs the local economy 391.4 m per year equating to £ 1,736 per smoker. Appendix 1.

2.2 Targets for next three years

The proposed target for smoking is a reduction of 2% in the next three years for prevalence of smoking amongst 18 years and over, routine and manual workers and an increase of 2% in the proportion of adults who have never smoked.

2.3 To achieve these targets the action plan for Ashford can be based on four strategic action areas:



Promoting Leadership in Tobacco Control

Leadership is necessary at all levels to drive forward change and reduce smoking prevalence levels. Reducing smoking prevalence rates requires a co-ordinated multi-agency, multi-sector partnership approach with clear outcomes to which members of the Ashford Health and Wellbeing Board are held accountable. Responsibility for tobacco control needs to be joined up and cross-boundary.

Reducing the uptake of smoking

- Preventing young people from starting to smoke
- Reducing access to tobacco products by young people

Reducing smoking prevalence levels

- Motivating smokers to give up
- Assisting smokers to give up using nicotine replacement therapy including E-cigarettes
- Target priority groups
- Enhance the role of primary and community care
- Smoking cessation in secondary care
- Workplace initiatives
- Increasing knowledge of smoking cessation and tobacco control through campaigns

Reducing exposure to second-hand smoke

- Promoting smoke-free environments
- Smoke-free cars
- Smoke-free homes

3. PRIORITY 2: OBESITY

Obesity is a significant problem in today's society and is predicted to worsen if nothing is done. It is linked to a range of health problems which both reduce individuals' life expectancy and quality of life. The Foresight report identified that the number of people that are obese in the UK had more than doubled in 25 years. The report predicted that by 2050, 60% of men, 50% of women and 25% of children in the UK could be obese, causing Britain to be a mainly obese society with factors such as income, gender and ethnicity increasing the impact of obesity in certain population groups. Britain is now the most obese nation in Europe. The majority of the adult population and 30% of children are either overweight or obese. The huge and rapid increase in the numbers of children and adults who are classified as obese has led to the use of the term "obesity epidemic" which has resulted in national policies, strategies and directives to address obesity that require the input of a wide range of agencies working with their communities.

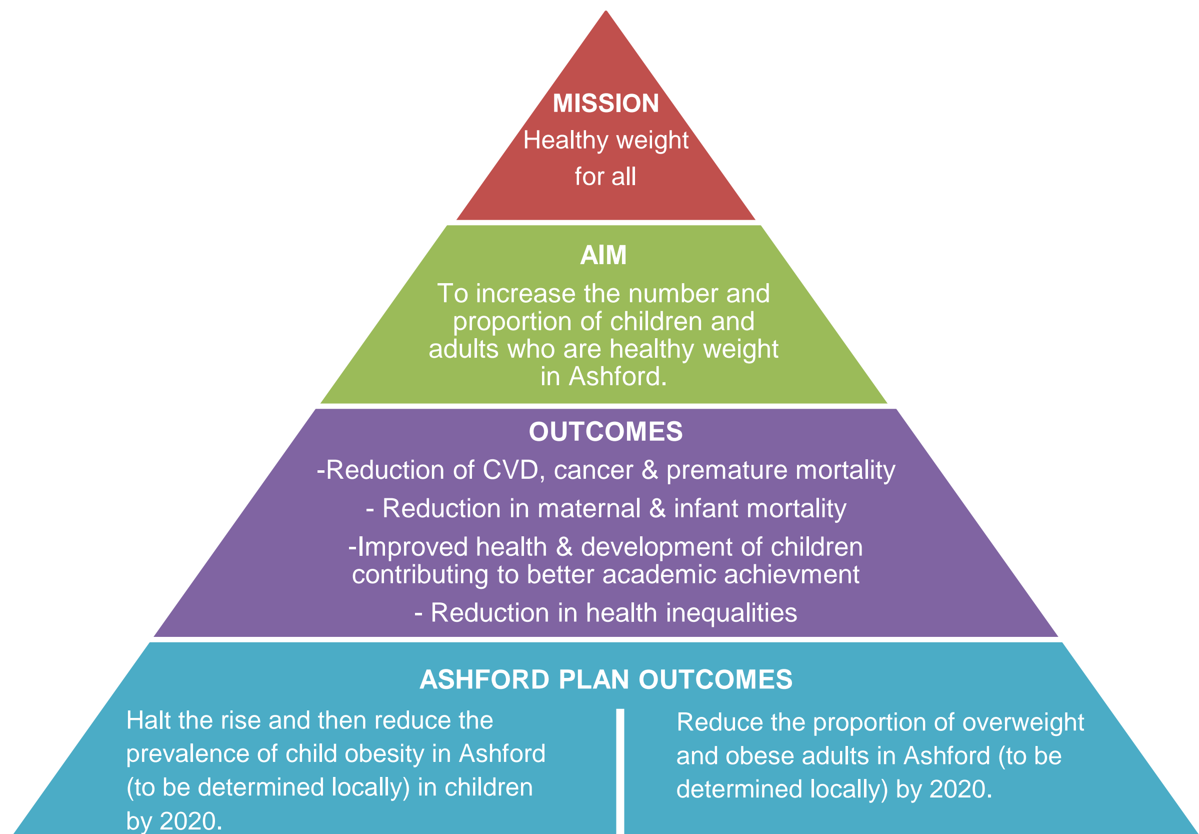
It is well documented that people who are overweight and obese increase the risk of a range of diseases that can have a significant health impact on individuals. Obesity is associated with type 2 diabetes and hypertension - which are major risk factors for cardiovascular disease and cardiovascular related mortality. Obesity has also been associated with cancer, disability and reduced quality of life, and can lead to premature death. Most importantly, there appears to be a link between obesity and level of deprivation.

The prevalence of adult obesity in Ashford is 67.5% as compared to 63.4% for the South East region and 64.6% for England. Rates are highest in Beaver, Stanhope, Norman and Aylesford Green wards. Appendix 2.

3.1 Targets for obesity

The national recommendation is that all areas should show a down ward trend in the prevalence of obesity and it will be reasonable for Ashford to also to aim for this.

3.2 Ashford Mission for obesity



3.3 Role of different organisations in taking forward the obesity action plan (NICE guidance)

Local Authorities	providing facilities and schemes such as cycling and walking routes, cycle parking, area maps and safe play areas making streets cleaner and safer, through measures such as traffic calming, congestion charging, pedestrian crossings, cycle routes, lighting and walking schemes ensuring buildings and spaces are designed to encourage people to be more physically active (for example, through positioning and signing of stairs, entrances and walkways) considering in particular people who require tailored information and support, especially inactive, vulnerable groups.
Early years	Nurseries and other childcare facilities should minimise sedentary

settings	activities during play time, and provide regular opportunities for enjoyable active play and structured physical activity sessions implement Department for Education and Skills, Food Standards Agency and Caroline Walker Trust guidance on food procurement and healthy catering.
Schools	Head teachers and chairs of governors, in collaboration with parents and pupils, should assess the whole school environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight, eat a healthy diet and be physically active, in line with existing standards and guidance. This includes policies relating to building layout and recreational spaces, catering (including vending machines) and the food and drink children bring into school, the taught curriculum (including PE), school travel plans and provision for cycling, and policies relating to the National Healthy Schools Programme and extended schools.
Workplaces	Workplaces should provide opportunities for staff to eat a healthy diet and be physically active, through active and continuous promotion of healthy choices in restaurants, hospitality, vending machines and shops for staff and clients, in line with existing Food Standards Agency guidance working practices and policies, such as active travel policies for staff and visitors a supportive physical environment, such as improvements to stairwells and providing showers and secure cycle parking recreational opportunities, such as supporting out-of-hours social activities, lunchtime walks and use of local leisure facilities.
Self-help, commercial and community settings	Primary care organisations and local authorities should recommend to patients, or consider endorsing, self-help, commercial and community weight management programmes only if they follow best practice
Health Visitors	Health professionals should discuss weight, diet and activity with people at times when weight gain is more likely, such as during and after pregnancy, the menopause and while stopping smoking.

Dr Faiza Khan
Consultant in Public Health
Kent County Council, March 2016

Appendix 1, Tobacco statistics for Ashford

Definition	Period	Count	Ashford	South East Region	England	South East Worst	South East Best
Smoking prevalence amongst persons aged 18 years and over	2014	-	26.4%	16.1%	18.0%	29.8%	6.1%
Prevalence of smoking amongst persons aged 18 years and over in the routine and manual group	2014	-	42.1%	26.4%	28.0%	45.3%	6.2%
Estimated deaths attributable to smoking per 100,000 population aged 35+	2011-2013	480	241.8	245.6	279.7	458.5	163.5
Directly standardised rates of smoking attributable admissions in people aged 35 +	2014/15	846	1211	1301	1671	2835	812
Index of multiple deprivation score (IMD 2010)	2010	-	15.3	-	21.7	4.5	43.4
Prevalence of smoking among persons aged 18 years and over	2014	-	26.45%	16.6%	18.0%	29.8%	6.1%
Prevalence of smoking among persons aged 18 years and over-ex-smokers	2014	-	34.7%	36.8%	33.9%	53.5%	14.4%
Prevalence of smoking among persons aged 18 years and over-never smoked	2014	-	38.9%	46.6%	48.1%	32.2%	68.3%
Prevalence of smoking among persons aged 18 years and over-	2014	-	20.6%	34.9%	30.8%	69.8%	11.6%

ex-smokers in routine and manual occupations							
Prevalence of smoking among persons aged 18 years and over in routine and manual occupations – never smoked	2014	-	37.4%	38.7 %	41.2%	13.5%	68.3%
Smoking prevalence in adults- current smokers (QOF)	2014/ 2015	18,338	18.6%	-	18.6%	27.2%	11.7%
Smoking prevalence modelled estimates – regular smokers aged 11-15 years	2009-12	201	3.3%	-	3.1%	4.8%	1.1%
Smoking prevalence modelled estimated- occasional smokers aged 11-15 years	2009-12	103	1.7%	-	1.4%	2.1%	0.5%
Smoking prevalence modelled estimates- regular smokers aged 15 years	2009-12	123	9.1%	-	8.7%	13.0%	3.2%
Smoking prevalence modelled estimates- occasional smokers aged 15 years	2009-12	62	4.6%	-	3.9%	5.5%	1.4%
Smoking prevalence modelled estimates- regular smokers aged 16-17 years	2009-12	466	15.4%	-	14.7%	21.2%	5.7%
Smoking prevalence	2009-12	204	6.8%	-	5.8%	8.1%	2.2%

modelled estimates- occasional smokers aged 16-17							
Estimated deaths attributable to smoking per 100,00 population, aged 35+	2011-13	480	241.8	245.6	279.7	458.5	163.5
Age-standardised rate of mortality from lung cancer per 100,000 population	2012-14	179	52.4	49.8	59.5	107.7	29.8
Age-standardised rate of mortality from chronic obstructive pulmonary disease per 100,000 population	2012-14	148	43.5	44.6	51.7	103.6	23.5
Smoking attributable deaths from heart disease	2012-14	51	24.6	24.2	29.7	58.1	16.1
Smoking attributable deaths from stroke	2012-14	-	-	7.7	9.3	-	-
Premature live births (gestational age less than 37 weeks) and still births per 1,000 live births and stillbirths	2010-12	-	-	-	-	-	-
Directly standardised rate of Smoking Attributable Admissions in people aged 35 and over	2014/15	846	1,211	1,301	1,671	2,835	812
Cost per capita of smoking attributable hospital admissions	2011/12	2,393,198	35.0	33.2	38.0	59.3	23.0
Age-standardised registration rate for lung cancer per	2010-12	214	67.0	67.0	76.0	146.8	40.1

100,000 population							
Age-standardised rate for oral cancer registrations per 100,000 populations	2010-12	31	9.4	9.4	13.2	21.6	6.4
Fatalities from accidental fires ignited by smoking materials and cigarette lighters	2013/14	-	-	-	72	-	-
Accidental fires ignited by smoking related materials	2013/14	-	-	-	3,300	-	-

Appendix 2, Obesity statistics for Ashford

Definition	Period	Count	Ashford	South East Region	England	South East Worst	South East Best
% of adults classified as overweight and obese	2012-14	-	67.5%	63.4%	64.6%	74.8%	46.0%
% children aged 4-5 classified as overweight or obese	2014-15	334	23.6%	20.3%	21.9%	30.7%	14.9%
% children aged 10-11 classified as overweight or obese	2014-15	447	34.0%	30.1%	33.2%	43.2%	21.1%

Appendix 3, List of indicators for which Ashford is significantly worse as compared to South East region and England.

Definition	Ashford Value
Rate of people reported killed or seriously injured on the roads , all ages, per 100,000 resident population.	50 per 100,000
Homelessness acceptance per 1000 households.	3.3 per 1000 households
Crude rate of violence against the person, offences per 1000 population.	13.2 per 1000
Rate of Chlamydia detection per 100,000 young people aged 15-24 yrs.	rate 1,368 per 100,000
Late diagnosis of HIV	50%
Cardio Vascular Disease: Hypertensive patients who were given lifestyle advice in the last 12 months.	68.3%
Smoking: Smokers aged 15+ with a record of an offer of support and treatment in the last 24 months.	80.8%
NHS Health Check: Cumulative percentage of eligible population aged 40-74 offered an NHS Health check who received an NHS health check.	34.7%
COPD patients with MRC dyspnoea score >=3 w oxygen saturation value (last 12 months)	88.7%
Breastfeeding initiation: percentage of mothers who breastfeed in the first forty eight hours of delivery.	71.3%
Obesity: Percentage of adults classified as obese or overweight.	67.5%
Smoking: Prevalence of smoking amongst people aged 18+.	26.4%
Smoking: Prevalence of smoking amongst people aged 18+ from the routine and manual groups.	42.1%
Most cancers in Ashford are being diagnosed at a late stage of disease and majority are presenting as emergency admissions as compared to England average	
Ashford CCG has a high prevalence of stroke and transient ischaemic attack and atrial fibrillation .	
rate of people living with any neurotic disorder in Ashford, (124.1 per 1000 people) may be lower than the Kent and Medway district average. The projected increase in common mental disorders by 2020 in Ashford is actually the highest amongst all the Kent CCGs. The overall increase from 2013 to 2020 of common mental disorders amongst 18-64 year olds is projected to be 9.87%. This means addressing mental health need within the Ashford CCG community must be a priority.	124.1 per 1000
Prevention to be included in all pathway work; both primary and secondary. Everybody's business thus Making Every Contact Count (MECC) a priority for all Commissioners	
Integration between NHS, Adult Social Care and Public Health to	

prevent ill health and lifestyle diseases, and tackling their determinants Reducing the gap in health life expectancy	
Spend on vision, neurology, infectious diseases, skin, poisoning and endocrine adverse effects	
Unplanned hospital admissions for chronic ambulatory care sensitive conditions	
% of alcohol users treated who did not re-present within 6 months	
Dementia diagnosis rate	
% of dementia patients who had a face to face review	
Rate of emergency admissions aged 65+ with dementia	
% of emergency admissions with dementia who stay 1 night or less	
Reported to estimated prevalence of CHD	
Employment rate difference between those with LTC and all of those of working age	
Rate of emergency admissions aged 75+ with a stay in hospital of less than 24 hours	
Unplanned hospitalization of chronic ambulatory care sensitive conditions	
% of people aged 16+ classified as inactive	
% of people aged 40-74 receiving a health check	